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WANTED: ONE GOOD DOCTOR.
DEPICTIONS OF THE GOOD PHYSICIAN IN
TWELVE AMERICAN NOVELS:
1859-1925

BONNIE ELYSSA GOULD

Yale University

1994

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Wanted: One Good Doctor.
Depictions of the Good Physician in Twelve American Novels:
1859-1925

A Thesis Submitted to the Yale University School of Medicine in Partial Fulfillment of the
Requirements for the Degree of Doctor of Medicine

by
Bonnie Elyssa Gould
1994

ABSTRACT

WANTED: ONE GOOD DOCTOR. DEPICTIONS OF THE GOOD PHYSICIAN IN TWELVE AMERICAN NOVELS: 1859-1925. Bonnie Elyssa Gould (Sponsored by John Harley Warner). Department of the History of Medicine, Yale University, School of Medicine, New Haven CT.

The 1990's physician has grown acutely aware of his professional authority's recent dissipation. Thirty years ago, physicians practiced in an atmosphere of autonomy, respect and prestige, enjoying rewarding relationships with both colleagues and patients. Comparatively, today's physicians are challenged with convoluted insurance practice guidelines and reimbursement policies, confrontational patients and malpractice threats. Shifts in both the physician's medical management style and bedside comportment have been accredited with precipitating the doctor's fall from a charismatic figure whose problem-solving powers were embedded in mystery to that of a professional man with ordinary endowments. Fueled by the national drive for health care reform, the medical profession is on the threshold of a significant redefinition of its professional identity and authority. Rather than allow for nonmedical health care reformers, physicians should seize this opportunity to actively reestablish their own professional authority independently of outside sources. At the crux of this reemerging identity is reasserting the cult of the 'good doctor'; the trusted physician. Defining the 'good physician' requires a systematic analysis of those personality traits, character limitations and professional mannerisms that ultimately coalesce into the preferred practitioner. The late nineteenth and early twentieth centuries represented a period when physicians were recognized as having achieved good doctoring. By exploring twelve American novels written within the period between 1859 and 1925, aspects of medical education, the doctor/patient relationship and professional authority which

contributed to the contemporary good doctor's mystique have been isolated. As good doctoring is strongly influenced by an era's socio-political setting, its pattern of evolution from 1859 to 1925, reflecting social changes, is also presented. Through acquiring a renewed appreciation of acknowledged good doctoring, a fresh outlook on the 1990s physician's future prospects can be established.

To my parents, Linda and Bert Gould, and my brother Martin, who, for fifteen years, have supported, challenged and encouraged my dream of becoming a doctor. Yet, this thesis symbolizes more than the completion of my formal medical training-obtaining the M.D.. My family has also taught me many important ideals. My father: the necessity of a thorough knowledge base and the ability to derive things from first principles. My mother: the importance of self-confidence, elegance and an easy smile. My brother: the importance of 'menschelkeit'; being a kind, compassionate and generous person. Researching my thesis, I have been constantly reminded of how my family's ideals are prominently featured in the 'good doctor' composite. I dedicate this thesis to my family for providing me with the requisite tools such that my own medical career can emulate that of the 'good doctor' developed within this work.

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INTRODUCTION: THE CLINTON INITIATIVE

Unveiling his Health Security Plan on September 22, 1993, President Bill Clinton marked 1994 as a watershed year for American health care. Challenged with over 37 million uninsured Americans and millions more severely underinsured, the President set forth a plan aimed at restructuring the current system for health care delivery. The plan centers around six initiatives: security of guaranteed coverage, simplicity in paperwork, savings to gross domestic product, choice of provider, quality of services and overall responsibility¹. If successful, the plan would redistribute the nine hundred billion dollars [one seventh (14%) of the American gross domestic product (GDP)²] currently expended on health care. Left unchecked, this figure threatens to spiral to 19% of the GDP by the end of the decade³. The nation has reached a consensus on the necessity for reform. Both social advocates of universal coverage and large corporations frustrated with spiraling health insurance premiums agree to restructuring the current health care delivery infrastructure⁴.

The plan's motive force would be "managed competition", a compromise reconciling the American preference for the free market and health care's assumed privileged immunity to market forces. Under managed competition,

¹John C. Roberts, "Clinton Outlines Plan to Fix American Health System", *British Medical Journal*, vol. 307 (1993), pp.819-820.

²Art Caplan, "Clinton's Health Care Reforms", *British Medical Journal*, vol. 307 (1993), pp. 813-814.

³Mark McCarthy, "Clinton Health-Care Reforms", *Lancet*, vol. 342 (1993), p.486.

⁴Caplan, *British Medical Journal*, pp.813-814.

the federal government would establish a National Health Board to oversee the individual states' distribution of their health care budgets. Each state would organize citizens geographically into 'regional health alliances' to purchase its constituents group health insurance plans⁵. Insurance plans would then enlist health care providers able to supply maximal benefits for minimal cost. Health maintenance organizations (HMO's) and independent practice associations (IPA's) would be the lowest bidders⁶. Already, managed care is motivating medical organization. Unable to compete, an increasing number of today's private solo practitioners are joining these medical conglomerates⁷. Academic medical centers fear for their own obsolescence. Their specialist attention to rare disorders eliminates their managed care competitiveness and could threaten medical education's teaching patient pool⁸. Ultimately, patients face restricted physician choices⁹.

In the midst of the thrust to regulate health care's finances, insurance, paperwork and organization rests the physician. The debates' constant jostlings have unearthed many dormant issues regarding patient care and have challenged the physician's professional authority and identity.

The health care debates have redefined the physician's future role within the context of an overhauled infrastructure. Already, the discussions have

⁵"Clinton Campaigns for Health Reforms", *Nature*, vol. 365 (1993), pp. 281-282.

⁶Arnold S. Relman, "Medical Practice Under the Clinton Reforms-Avoiding Domination by Business", *The New England Journal of Medicine*, vol. 329 (1993), pp.1574-1576.

⁷Harris Meyer, "Reform or Not, Managed Care is Shaping the Future", *American Medical News*, (Jan. 10, 1994) p. 3, and Richard Horton, "Clinton's Vision on Health", *Lancet*, vol. 342 (1993), pp. 732-733.

⁸Helaine Patterson, "Health Care Reform: One Dean's Perspective", *Yale Medicine*, (Fall/Winter 1993-1994) pp.2-5.

⁹Art Caplan, *British Medical Journal*, pp.813-814.

threatened major restructuring and limitations to the physician's professional role. Within the context of managed care, cost effectiveness has stimulated proposals for 'practice guidelines'-set algorithms defined by a Congressional committee outlining exact management plans for every illness, contingency and complication¹⁰. Within these narrow guidelines, physicians would be stripped of creative autonomy, threatening the doctor/patient relationship's individuality.

The plan's proposed universality of coverage would also press the physician's ethical limits. As health care providers, physicians will be challenged with dispensing the nations limited health care resources. Presently, access to intensive procedures including liver and heart transplantations is limited by requiring partial patient subsidization. Should universal coverage fully insure transplantations, countless additional patients would join the already overcrowded waiting lists and clamor for priority¹¹. Managing limited resources will compromise adequate provision for the aging American population's every health care necessity¹². Ultimately, the physician as health care provider and coordinator would shoulder these triage responsibilities. Concerns have been raised around intolerable waiting lists for cutting-edge medical technologies¹³ and the potential for the formation of a two-tiered medical system, leaving lower socioeconomic groups with insufficient and possibly substandard care¹⁴. Physicians would be liable for these deficiencies.

¹⁰Glen C. Griffen, "Clinton and Clinton Tort Reform: An Imaginary Conversation Between Bill and Hillary", *Postgraduate Medicine*, vol. 94 (1993), pp.21-24.

¹¹Patterson, *Yale Medicine*, pp.2-5.

¹²Victor R. Fuchs, "Dear President Clinton", *JAMA*, vol. 269 (1993), pp.1678-1679.

¹³William L. Kissick, "Health Policy: Ten Percent Legislation, 90 Percent Implementation", *Yale Medicine* (Fall/Winter 1993/1994) pp.7-8.

¹⁴Pilar N. Ossorio, "Ethics Working Group Experiences Inspiring, Humbling", *Yale Medicine* (Fall/Winter 1993/1994), pp. 8-10.

With health care repeatedly capturing national headlines¹⁵, renewed interest in the physician's current status and authority within American society has emerged. Despite most Americans claiming satisfaction with their doctor¹⁶, the physician has grown acutely aware of the dissipation of medicine's 'golden age' and the resulting delicate foundation balancing his professional authority. 1990's medicine has radically changed from that practiced even thirty years ago. Physicians characterize that era as one of "autonomy, respect and prestige"¹⁷. Despite the longer hours and the relative technologic deficiencies, they enjoyed rewarding relationships with both patients and colleagues. Today, physicians recognize that their professional respect has considerably waned¹⁸. Physicians, constantly threatened with potential malpractice legislation, are required to practice 'defensive medicine' and order clinically unnecessary tests accumulating sufficient data to offset a potential court order¹⁹. In his essay *American Medicine's Golden Age: What Happened to It?*, John C. Burnham accredited the recent decline in medicine's professional authority to changes in both medical

¹⁵Media sensationalists have capitalized on the health care debates to launch multiple stories on medical injustice. Malpractice lawsuits have filtered to network television. Newsmagazine programs repeatedly feature essays on the patient's perspective of medical mismanagement. Comparatively few stories of medical successes reach the popular press. This constant barrage of media has contributed to the physician's loss of professional authority. Anne Stein, "The Profession Isn't What It Used to Be", *American Medical News* (Jan. 10, 1994), pp.4-5.

¹⁶Fuchs, *JAMA*, pp.1678-1679.

¹⁷Stein, *American Medical News*, pp.4-5.

¹⁸Ibid., pp.4-5.

¹⁹Thirty years ago, patients had placed their physicians on a pedestal and were rarely inclined to sue. Presently, the country has adopted the notion that any unfortunate medical outcome, irrespective of causality, is ultimately the physician's blame. Patients and third parties more frequently question physicians' judgments, plaguing the medical profession with a proliferation of malpractice litigation. Griffen, *Postgraduate Medicine*, pp.21-24, and Stein, *American Medical News*, pp.4-5.

management²⁰ and physician bedside comportment²¹. The physician had fallen from "a charismatic figure, who used mysterious powers to resolve problems, to one with ordinary endowments and who could potentially behave unheroically"²². These tensions have subsequently precipitated conflicts among physicians²³, further weakening medicine's professional stance.

The medical profession is on the threshold of a significant redefinition of its professional identity and authority. Already, nonmedical motivations including managed care, tort legislation and popular journalism have encroached into the physician's autonomy. Change is inevitable. Tarnishes to the physician's image intermingled with the challenges of creating adequate national health care delivery have initiated the process. However, this redefinition only starting to unfold. Its eventual course has yet to be determined. Medical professionals, by claiming an active, prominent role in redefining their

²⁰The 1950's heralded an important shift in the profile of sick Americans. The country witnessed a startling increase in the number of patients with chronic illnesses. The physician had, in part, attained the 'golden age' esteem through his ability to successfully arrest acute disease progression. Physician impotence in treating chronic illness fostered a resurgence in patient disillusionment with physician capabilities. John C. Burnham, "American Medicine's Golden Age: What Happened to It?", in *Sickness and Health in America*, ed. by Judith W. Leavitt and Ronald L. Numbers (Madison WI, University of Wisconsin Press, 1985) pp. 248-258.

²¹The 1970's cult of individualism precipitated increased patient interest and involvement in their own health care. In seeking optimal care, patients grew increasingly critical of physician behavior and freely exchanged physicians until happening on one whose bedside and therapeutic style matched their expectations. *Ibid.*, pp.248-258.

²²*Ibid.*, pp.248-258.

²³Responding to President Clinton's plan, the American Medical Association's House of Delegates altered its position on health care financing by broadening its stance to allow individuals as well as large corporations to purchase health insurance. Two days later, members of the American Academy of Family Physicians, American College of Physicians and American Academy of Pediatrics (the representative 'primary care' colleges) organized a news conference with both President and Mrs. Clinton and contradicted the AMA's position. Many physicians regard these squabbles as evidence for a weakened medical profession, an image ill-affordable in this age of reform. "Professional Unity: Reform Stakes Too High to Risk Squabble Over Strategy", *American Medical News* (Jan. 10, 1994), p.20.

own identity, can reestablish their professional authority independently and autonomously from nonmedical outsiders.

At the crux of this change is reestablishing the cult of the 'good doctor'. Eric J. Cassell categorizes a 'good physician' as one "who is trustworthy, and a trustworthy physician as one who has self-discipline"²⁴. The good doctor is one on whom a sick patient readily bestows complete trust in the caretaking of his illness. Incumbent on the medical profession is to dispel the public's negative perceptions by uniformly reaffirming the 'good doctor' ideal.

Delineating those characteristics required of the good doctor is more challenging. The requirements of knowledge and professional competence are readily acknowledged. Yet, good doctoring extends beyond possession of these. Cassell suggests that good doctoring encompasses "taking histories, establishing rapport, achieving compliance with regimens that may be extremely unpleasant, being sensitive to unspoken needs, providing empathetic support and communicating effectively"²⁵. This catalog, however, only describes the *outcome* of good doctoring. It fails to elucidate those physician traits which provoke the stated outcomes-the characteristics inherent in the good doctor.

The epitomized late nineteenth- and early twentieth-century physician has been recognized as having achieved the ideal of good doctoring. On a superficial level, this has been attributed to the physician's reinforcement of individuality within the contexts of both patient illnesses and his own personality²⁶. Nonetheless, despite overall good doctoring, there existed a full spectrum of physician quality and competence. Good doctors must have

²⁴Eric J. Cassell, "The Changing Concept of the Ideal Physician", *Daedalus*, vol. 115 (1986), p.201.

²⁵Ibid., p.203.

²⁶Ibid., pp.185-206.

distinguished themselves on a more substantial basis than their individuality. A systematic analysis cataloguing those personality traits, character limitations and professional mannerisms integral to the good physician would facilitate maximal appreciation for late nineteenth- and early twentieth-century good doctoring. This has yet to be accomplished.

By exploring twelve American novels written within the period of 1859 to 1925, I have attempted to isolate and explore those characteristics and traits essential to the late nineteenth- and early twentieth-century American society's good doctor. Specifically, I have examined how aspects of medical education, the doctor/patient relationship and professional authority contributed to the good doctor mystique. However, good doctoring, strongly influenced by an historical period's socio-political setting, persisted in state of flux and evolution across my period of study. The specific components essential to good doctoring as well as their pattern of evolution between 1859 and 1925 are discussed. Through acquiring a renewed appreciation of acknowledged good doctoring, a fresh outlook on the contemporary physician's future prospects can be established.

MATERIALS AND METHODS: DISCUSSION OF THE NOVELS

For this analysis of the 'good physician', I have selected literary novels as my primary historical documents. Novels from the late 19th and early 20th centuries are particularly known for their critical realism²⁷. In particular, they offered a reasonably revealing insight of their contemporary societies' events, styles and mannerisms. In this respect, their effectiveness would parallel that of historical documents and biographies. However, unlike these latter two sources, the novels offered additional advantages that established them as particularly intriguing documents for studying the issues of physician character and quality.

The novelist, especially one commenting about his contemporary time period, had loftier goals than simply creating a narrative for financial remuneration. The author wrote to either celebrate or critique a captivating element of his society. To create an easily recognizable setting, the novelist strove for an accurately detailed societal portrait. Yet, the novel's bulk is sculpted through the author's perceptions, ideas and biases. The novelist, being immersed himself or herself in the featured era, commented on the quality and effectiveness of those preferred social institutions shaping his/her daily life. Therefore, the novel was not limited by teasing the reader with a glimpse into

²⁷Critical realism was developed by mid nineteenth century authors, both American and European (e.g. Flaubert, Dickens, Tolstoy James), from its precursor, formal realism. Both realistic styles strive to have art approximate reality. This is where the similarities end. Unlike formal realism which attempts to authentically define characters through broad-stroked but accurate portrayals of their surroundings, actions and reactions, critical realism carries the art of detail to new depths. Through use of painstakingly microscopic detailing of scenes and events, these authors sought to decode the significance of life's events rather than merely record their passing. It is through extensive use of carefully selected descriptive terminology that the authors attempted to analyze rather than just accept their sociologic status quo and it is this elaborate use of detail with which they hoped to uncover the whole truth about events that shaped their lives. Lawrence Rothfield, Vital Signs: Medical Realism in Nineteenth Century Fiction, (Princeton, Princeton University Press, 1992) pp.6-7.

the social fabric of a past era and forcing him to reflect from his own present-day perspective. The novel, through the author's comments and feelings, also provided insight into the same society from an active participant's point of view. Furthermore, as some of the selected authors were physicians themselves (Oliver Wendell Holmes, Sr.²⁸ and Silas Weir Mitchell²⁹) or had close friends and associations with the medical and scientific communities (Sinclair Lewis³⁰,

²⁸ Oliver Wendell Holmes studied medicine in the early 1830's at Harvard, followed by three years of studies in Paris under the auspices of Dr. Louis, the renowned diagnostician. Upon returning to the States, he was appointed physician at the Massachusetts General Hospital and from 1847 served as a Harvard medical professor. Clinically, Holmes was noted for a "practice [that] was milder than that of some more assertively heroic physicians" and for stating that "if the whole *materia medica*, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind-and all the worse for the fishes". John Harley Warner, The Therapeutic Perspective: Medical Practice, Knowledge and Identity in America, 1820-1885, (Cambridge Mass. and London, England, Harvard University Press, 1986) pp. 28-29 and William G. Rothstein, American Physicians in the Nineteenth Century, (Baltimore, The Johns Hopkins University Press, 1972) pp.178-179. In 1870-71, still active at Harvard, Holmes led the opposition to Eliot's reforms of Harvard medical school, skeptical that "laboratory science would provide as rich a source for therapeutic advance as clinical observation". Thomas S. Huddle, "Looking Backward: The 1871 Reforms at Harvard Medical School Reconsidered", *Bulletin of the History of Medicine*, vol. 65 (1991), pp.340-365. Concurrent to his clinical responsibilities, Holmes actively wrote both prose and poetry.

²⁹ Mitchell was born in 1829, the son of a Scottish physician. He graduated from Jefferson Medical College in 1850 and pursued one year in Paris. During the Civil War, he acted as assistant surgeon in an army hospital for soldiers suffering from nerve injuries. Thus launched Mitchell's famed career as a neurologist; he was eventually elected president of the American Neurological Association. Mitchell was also an advocate for public health, campaigning in the 1880's as President of the College of Physicians of Philadelphia. Socially, his acquaintances included both prominent physicians (Hideyo Noguchi, Oliver Wendell Holmes, Sr., William Osler) and literary men (William Dean Howells, Henry James). Whitfield J. Bell, Jr., "S. Weir Mitchell in the College of Physicians of Philadelphia", *Transactions and Studies of the College of Physicians of Philadelphia*, vol. 12 (1990), pp.9-26 and William Wiegand, "Introduction to In War Time", (Albany, NY, NCUP Inc., 1990).

³⁰ Although Sinclair Lewis himself was not a physician nor a scientist, he collaborated with established scientist Paul de Kruif to gather appropriate background with which to frame Arrowsmith (1925). This included a two-month steamer ship to the Caribbean islands where Lewis acknowledged that de Kruif provided "most of the bacteriological and medical material in this tale". Howard Gest, "Dr. Martin Arrowsmith: Scientist and Medical Hero", *Perspectives in Biology and Medicine*, vol. 35 (1991). pp.231-250.

Andrew Jackson Davis³¹), first-hand, almost autobiographical, perspectives could be gleaned from this genre. This was especially important in evaluating ephemeral standards including cutting-edge therapeutics and doctor/patient interactions. Conditions and practices that by today's standards are considered primitive and unfathomable may have once been highly prized and sought after. Missing this perspective would detract from appreciating public satisfaction and acceptance of their health care and its providers.

Two literary techniques that facilitated the novel's analysis thus enhancing its appropriateness as a primary source, included the exaggerating caricature and the character foil. The exaggerated caricature was especially designed for separating a spectrum of character traits which, in real life, only subtly differed among selected individuals. Independent of his realist objectives, the novelist created characters with selectively exaggerated personality traits uniquely designed to emphasize observed human behavior patterns. It is through this caricatured perspective that a personality trait's or behavior pattern's absurdity or usefulness can be unequivocally assessed. The character foil was similarly useful for exploring the relative contributions of various personality styles. In creating a foil, a novelist honed in on specific traits or behaviors his protagonist displayed and then constructed a character to diametrically oppose these selected characteristics. As both characters navigated through similar life circumstances, the reader could appreciate the differing impact each personality had on a given society or situation. Not only has the foil given contrasting perspectives on a single issue but it frequently allowed for

³¹Between the ages of seventeen and nineteen, Davis peddled himself as a spiritualist. Having adopted mesmerism, he claimed to possess a clairvoyant power and opened a marginally successful spiritualist clinic. Herbert W. Schneider and Ruth Redfield, "Davis, Andrew Jackson", *Dictionary of American Biography*, vol. 5 (1931) p.105.

demonstration of an idealized style of behavior; either the revered 'right' way to proceed, or the decidedly 'wrong' one. The novelist not only offered a critique of a given behavior pattern but also presented his opinion for a more appropriate course of action. In defining those traits seminal to the good physician, both of these techniques potentially provided further insight into contemporary thoughts and expectations regarding both the ideal and the irritating physician.

The use of literary texts for scholarly critique of physicians' lifestyles, professionalism and ideals is not new. Since 1916 when Edna Kenton openly griped about the image of women physicians as portrayed in eight nineteenth century novels³², many books and doctoral dissertations, as well as numerous articles have attempted to understand various facets of a physician's motivation. Some have sought to obtain a sense of the image of the physician across a specific time period. Evelyn Wilbanks, in 1972, examined three American novels, including Cable's Dr. Sevier (1885), to delineate the perception of physician omnipotence within the nonmedical society and, in an age of literary escapism, as the idealized Romantic hero³³. Alex John Cameron, in his 1973 doctoral dissertation considered over fifty American 'doctor' novels from 1859-1925 to examine the physician in a more religious context. By presenting both the doctor's fatherly demeanor and the religious overtones towards his tasks, Cameron argued that the physician often supplanted the priest as the spiritual center of his practice population³⁴. More recently, Melissa McBain used the

³²Edna Kenton, "The Pap We Have Been Fed On-Eight Lady Doctoresses of Nineteenth Century Fiction", *Century Magazine*, November 1916, pp.280-287.

³³Evelyn R. Wilbanks, "The Doctor as Romantic Hero-A Study of Idealization", *JAMA*, vol. 220 (1972), pp.54-57.

³⁴Alex John Cameron, The Image of the Physician in the American Novel 1859-1925, (Ph.D. Dissertation, University of Notre Dame, 1973).

literary medium of drama to explore growing public dissatisfaction with their physicians. These complaints stemmed from the perceived prioritization of financial gains above the responsibility towards patient care³⁵. Dissertations by David E. Stooke and Janice Willms also dealt with the general image of the nineteenth- and early-twentieth-century physician as portrayed in American novels³⁶.

The second class of these works attempted to describe a specific historical movement or attitude through use of contemporary novels. One such theme was the development and assimilation of experimental medical science into the predominantly clinical profession. Lois DeBakey's 1966 dissertation, The Physician Scientist as a Character in Nineteenth Century American Literature, argues that all major issues perceived as either intrinsic dangers or external threats to the medical profession could be found depicted in nineteenth-century American medical fiction. While the infiltration of basic science was shown to be the most marked concern, secondary threats such as the entrance of women into the profession were also included³⁷. A more recent text by Philip A. Scott, using

³⁵Melissa McBain, "The Changing Concept of the Ideal Physician in Late Nineteenth and Early Twentieth Century American Drama", *Journal of Popular Culture*, vol. 26 (1992), pp.33-40.

³⁶Stooke's 1976 dissertation, "The Portrait of the Physician in Selected Prose Fiction of Nineteenth Century American Authors", described physician characteristics as portrayed in the novels of seven nineteenth-century authors (including Oliver Wendell Holmes, Sr., William Dean Howells and George Washington Cable). Willms's more contemporary (1990) effort, "An Historical Interpretation of the Physician in American Fiction: 1830-1935", dealt with the relationships between physicians and the evolution of medical science within the ascribed time period. She noted that although the physician's role changed with medical scientific advances, it was more profoundly affected by changing cultural pressures and ideals. David E. Stooke, "The Portrait of the Physician in Selected Prose Fiction of Nineteenth Century American Authors", *Dissertation Abstracts International* vol. 37 (Feb. 1977) p.5130-A, and Janice Willms, "An Historical Interpretation of the Physician in American Fiction: 1830-1935", *Dissertation Abstracts International*, vol. 51 (Apr. 1991), pp. 3414-3415.

³⁷Lois DeBakey, The Physician-Scientist as Character in Nineteenth Century American Literature, Ph.D. Dissertation, (Tulane University 1966).

Arrowsmith (1925) as his flagship novel, examined the twentieth-century phenomenon of the medical scientist-the "modern physician with a scientific curiosity"-and the impact of his quest for fundamental truths of nature on both his professional and personal life³⁸. Chester R. Burns chose to use fictional doctors as a method to analyze the evolution of American medical ethics in the last quarter of the nineteenth century³⁹. Sonya S. Erickson, to contextualize the challenges today's women physicians face as a result of the portrayal of female physicians in current popular culture, selected ten Victorian-American novels featuring female physicians to organize their challenges against contemporary culture as a foil for the present day experience⁴⁰. Mary Ann Cook studied the trends of patient satisfaction with the doctor/patient relationship from eighteen works of fiction, spanning the North American and European continents from 1863 through 1978⁴¹. In a different vein, Lawrence Rothfield utilized the nineteenth century European medical novel as a method of demonstrating the philosophic tenets behind the movement of literary realism. Rather than use literature to enhance the appreciation of medicine, he has selected the opposite;

³⁸Philip A. Scott, The Medical Research Novel in English and German, 1900-1950, (Bowling Green State University Popular Press, Bowling Green, Ohio, 1992).

³⁹Burns explored seven novels, including works by George Washington Cable, William Dean Howells and Robert Herrick to gain insight into contemporary thought concerning the ethical issues of interphysician consultation, professional male-female relationships and the physician obligations to attend to the moral wellness of their patients. Chester R. Burns, "Fictional Doctors and the Evolution of Medical Ethics in the United States, 1875-1900", *Literature and Medicine*, vol. 7 (1988), pp.39-55.

⁴⁰Sonya S. Erickson, The Image of the Woman Physician in Ten Victorian American Novels, M.D. Thesis, (Yale University, 1991).

⁴¹Mary Ann Cook, Patient Satisfaction with Patient-Physician Interaction: an Historical View Through Literature, Ph.D. Dissertation, (St. Louis University, 1988).

understanding the changes that affected medicine to gain additional appreciation of its fictional literature⁴².

I have selected twelve American novels bracketing the time period from 1859 to 1925 from the bibliography A.J. Cameron generated for his 1973 doctoral dissertation⁴³. The novels were specifically selected for possessing the two following characteristics: white Judeo-Christian males featured as the principal and supporting physicians and a 'slice of life' perspective (with the specific exclusion of allegorical novels) presented as the motif.

All selected novels portrayed a white male of Judeo-Christian background as the protagonist. I honed on this criterion of exclusion for two reasons, one historical and one social. Historically, the medical profession's accessibility to white men, unlike that to women and racial minorities, remained consistent throughout the time period in question⁴⁴. Although different sectarian styles, such as Eclecticism, Homeopathy, Thompsonianism and Osteopathy, had their popularity wax and wane during this period and the number as well as quality of medical schools was constantly fluctuating, all white men who wished to go to

⁴²Lawrence Rothfield, Vital Signs.

⁴³Alex John Cameron, Image of the Physician.

⁴⁴ The composition of the American physician's main ranks, although predominantly white males, did shift with respect to socio-economic status during the period from 1860 through 1925. The 1860's demonstrated a more varied composition of medical students. Upper-middle-class students unable to manage the prestigious law curriculum were joined by poorer classmates considered unsuited to join the family trade. Following the early twentieth-century decline in proprietary schools, the poorer students had fewer educational opportunities. The profession adopted a more homogeneous composition, weighted towards the middle-class. Gert H. Brieger, "Classics and Character: Medicine and Gentility", *Bulletin of the History of Medicine*, vol. 65 (1991), p.95, and Paul Starr, The Social Transformation of American Medicine, (New York, Basic Books, 1983) p.124.

medical school, provided they could produce the necessary tuition fees⁴⁵, could obtain admission at some institution and enter the profession⁴⁶. This was not the case with neither women⁴⁷ nor ethnic minorities (specifically African-Americans)⁴⁸. Neither community had continued open access to the medical establishment as did their male counterparts.

⁴⁵Tuition fees for attending a nineteenth-century American medical school were as follows. Just prior to the civil war, two methods of capitation existed. Most schools required a single payment at the beginning of a session. Fees ranged from \$150 at rural schools to \$285 at the urban ones. The second method, less popular by the 1850's, requested a \$15 enrollment fee, \$15 payable to each professor to gain admission to his class then \$15-\$20 graduation fee payable upon completion of one's thesis and passing medical licensing requirements. If a student failed, the school did not receive the latter payment. Rothstein, *op. cit.*, p.94.

⁴⁶Three classes of physicians evolved, divided along socioeconomic strata. The first included an elite group, born into cultured backgrounds and educated in preparatory school and college prior to attending medical school. Their social connections arranged for outstanding preceptorship and access to rare hospital experience. These men often supplemented their education with studies abroad. Ultimately, they formed the profession's leading practitioners (e.g. Oliver Wendell Holmes, Sr.). The second group included men from poor, often rural families. Despite poor formal education, they had tremendous intelligence, drive and ambition and self-educated themselves to reach the pinnacle of the medical profession (e.g. Nathan Smith Davis). The final group included men of both rural and urban lower classes with little education and average ability. Nonetheless, they met licensing requirements and entered the profession as the rank and file practitioner. Lester S. King, "Medicine in the USA: Historical Vignettes VI. Medical Education, the AMA Surveys the Problems", *JAMA*, vol. 248 (1982), pp.3017-3021.

⁴⁷Women were denied admission at most American medical schools through 1885. However, due in part to the Victorian concerns about the correctness of male physicians examining women's bodies, a brief period from 1885 to 1905 saw the both the surge of women's admissions at regular medical schools and the foundation of proprietary women's medical schools. The second half of the nineteenth century witnessed the founding of seventeen women's medical colleges. In 1894, as many as 1419 women were enrolled as medical students in the United States and by 1900, there were over 7,000 female physicians. As a result, many women entered the profession and engaged in successful careers. By 1909, partly due to the end of the Victorian mindset and partly due to male physicians' hostility towards female colleagues, women's enrollment began to wane, prompting Flexner's indifference to preserving women's access to the profession. The publication of the Flexner report forced many of these schools to close outright or merge with more established, male dominated institutions with strict quotas on admitting women. Women were forced again to struggle and compete for a severely limited number of medical school spots available to them and then for professional opportunities once having graduated. Starr, *op. cit.*, p.124.

⁴⁸Policies of racism and discrimination prohibited American Blacks from entering the mainstream American medical profession. However, the absence of white medicine's interest in the African-American community prompted the establishment of Black medical schools to provide caretakers for their own community. With their beginnings in the 1870's, independent Black physicians were the product of the Civil War Reconstruction period. While these schools were most popular in the

Secondly, these two groups had different social constraints placed upon them. African-Americans' practices were limited to their own community and they never but rarely integrated into the mainstream American medical society. They formed their own parallel societies⁴⁹ and established their own standards of care. Women were limited by the social constraints of their sex. Victorian society had strict definitions of what functions were and weren't proper for women. While a woman could engage in a meaningful and successful medical practice, her public's expectations were shaped by its adoption of the woman's cult of domesticity. Women were conspicuously lacking from leadership positions in medical societies⁵⁰, and in later times from prestigious positions at the major hospitals and medical clinics. Because of their differing professional environments and working constraints, the careers and styles of these groups diverged from the white male and it would be confounding to create of these groups one homogeneous collection.

1870's and 1880's, the continued poverty of the African-American community initiated a decline in these schools' viability. The Flexner Report drove the final stake; prior to the Report, seven schools eked out an existence. Afterward, only two survived. Star, op.cit., p.126.

⁴⁹By the 1890's, patterns of racial segregation were established throughout the medical profession. Due to the predominantly social function of major medical societies, Blacks saw the need to establish their own as they were largely excluded from the major ones already in existence. This effort culminated in 1895 with the establishment of the National Medical Association. Rosemary Stevens, American Medicine and the Public Interest, (New Haven and London, Yale University Press, 1972), p. 36.

⁵⁰ Dr. Sarah Hackett Stevenson, the first female member to the AMA joined in 1876 as the delegate from Illinois. Morris Fishbein, A History of the American Medical Association 1847-1947, (Philadelphia, W.B. Saunders, 1947), p.91. Each of the American Medical Association's first one hundred presidents were men. Between 1870 and 1905, prior to the establishment of quality American postgraduate training centers, the preferred method to acquire superlative specialist training was to attend a German University. The majority of the American profession's leading specialists had trained in Germany. Yet, the German schools automatically barred women from their classes until the dawn of the twentieth century. This further hindered a woman's establishment as a leader in her field. Thomas Neville Bonner, American Doctors and German Universities, (Lincoln, NE, University of Nebraska Press, 1963), p.27.

The decision to study the white male physician was not exclusively arrived at by simple exclusion of other practicing physicians. Despite the presence of both women and minority physicians between 1859 and 1925, the majority of the profession's founders, role models and rank & file members were male. In essence, the profession was, for the most part, shaped by the white male physician. Consequently, the most direct method to develop and understand the characteristics of the good physician would be to follow the evolution of its most prominent player, the white male physician.

The second criterion of exclusion was the genre of 'temperance novel', a common literary style employed from the 1880's on through the Progressive Era. All temperance novels followed a similar format: the development of a respectable, easily recognizable member of society followed by this righteous individual's seduction by either alcohol, opium or incessant carousing. The remainder of each novel was dedicated to painfully describing the individual's spiraling downfall including loss of professional respect, personal effects and loved ones to demonstrate the folly of pursuing these 'unchristian' vices⁵¹. While some temperance novels featured physicians as protagonists, the ultimate goal of the novel was not to examine physician style or behavior but to vilify the excessive use of alcohol. Consequently, the physician's professional character could easily be interchanged with that of a lawyer or a businessman. These novels' featuring a physician was both accidental and trivial. As a genre, having

⁵¹The Literary News magazine adopted the daunting task of guiding readers to the right books, a important consideration for the middle-class Victorian American population. Within this context, the journal describes a new subgenre, the 'novel of purpose'. The supposed 'purpose' was to 'teach a lesson or advocate a principle'. These literary works were isolated based on depicting a character whose mission it was, through example, to demonstrate the author's selected moral. Sonya S. Erickson, op.cit., p.13.

proved their point, these allegorical novels lacked the 'slice of life' candidness this study requires and were selectively excluded.

Finally, in selecting the novels, I attempted to obtain a reasonable cross-section of the available literature by including texts from a diverse group of authors. Famous authors (e.g. Oliver Wendell Holmes, Sr., Silas Weir Mitchell, William Dean Howells, Henry James, Robert Herrick and Sinclair Lewis) were combined with less renowned writers (e.g. James Oppenheim, Andrew Jackson Davis, Frank Hamilton Spearman and Joseph Crosby Lincoln). These authors hailed from diverse backgrounds, each having influenced the author's literary products. Appreciating these backgrounds is essential for contextualizing the various novels⁵². The majority of the authors settled in large cities; the balance were raised in small towns⁵³. With the exceptions of Howells⁵⁴, Davis⁵⁵ and

⁵²The following two paragraphs' references are included here: Charles W. Burr and Arthur Hobson Quinn, "Mitchell, Silas Weir", *Dictionary of American Biography*, vol. 13 (1934), pp.62-65; Oscar W. Firkins, "Howells, William Dean", *Dictionary of American Biography*, vol. 9 (1932), pp.306-311; Robert L. Gale, "Henry James", *Dictionary of Literary Biography*, vol. 12 (1982), pp.297-325; Charles Hackenberry, "James Oppenheim", *Dictionary of Literary Biography*, vol. 28 (1984), pp.203-207; Henry Beetle Hough, "Lincoln, Joseph Crosby", *Dictionary of American Biography*, supp. 3, (1973), pp.460-461; Martin Light, "Sinclair Lewis", *Dictionary of Literary Biography*, vol. 9 (1981), pp. 169-185; Barry Menikoff, "Oliver Wendell Holmes", *Dictionary of Literary Biography*, vol. 1 (1978), pp.106-113; Blake Nevius, "Herrick, Robert", *Dictionary of American Biography*, supp. 2 (1958), pp. 299-300; Herbert W. Schneider and Ruth Redfield, "Davis, Andrew Jackson", *Dictionary of American Biography*, vol. 5 (1931), p.105; Martin Torodash, "Keyes, Frances Parkinson", *Dictionary of American Biography*, supp. 8 (1988), pp.327-329; Tom H. Towers, "Robert Herrick", *Dictionary of Literary Biography*, vol. 12 (1982), pp.253-263; Carl Van Doren, "James, Henry", *Dictionary of American Biography*, vol. 9 (1932), pp.579-585; James Woodress, "William Dean Howells", *Dictionary of Literary Biography*, vol. 12, (1982), pp.270-297.

⁵³Henry James was born in New York City and frequently moved between New York and European centers including London and Paris. Robert Herrick and Oliver Wendell Holmes, Sr., both were born in Cambridge. Silas Weir Mitchell hailed from Philadelphia. Frank Spearman was born in Buffalo, N.Y.. George Washington Cable lived his youth in New Orleans. James Oppenheim was born in St. Paul, Minnesota but moved to Brooklyn, New York as a child. Of those from small towns: Joseph Lincoln lived on the Massachusetts cape. William Dean Howells was born in Belmont County, Ohio. Frances Keyes originated in Virginia. Andrew Jackson Davis was from Orange County, New York. Sinclair Lewis grew up in the Minnesota frontier town of Sauk Center.

⁵⁴Howell's father was a migratory, ill-paid anti-slavery journalist in Ohio. Howells began working at the age of seven setting type for his father's journal. William Dean, having taught himself to read

Lincoln⁵⁶, the authors were all raised in middle- to upper-class societies.

University education figured prominently for most. Harvard was most popular, enrolling Holmes, Herrick, and James. Oppenheim briefly studied at Columbia, Lewis at Yale⁵⁷. Mitchell attended Jefferson Medical College. Keyes had been accepted at Bryn Mawr but marriage pre-empted her studies. Cable taught at Smith College. Howells received honorary degrees from Oxbridge and refused professorships at prominent institutions including Harvard and Yale.

For some of the authors, particular life experiences motivated their works selected for this study. Lincoln exploited his childhood experiences and set Dr. Nye of North Ostable (1923), like many of his works, on the Massachusetts cape. Cable's attachment to the New Orleans of his youth prompted several works including Dr. Sevier (1885), capturing this bygone era's lifestyle. Howells drew upon his Cambridge experiences for The Undiscovered Country (1880). Keyes's paternal grandparents settled in Newbury, Vermont, provoking The Career of David Noble (1921)'s initial setting. In addition, Keyes thoroughly researched her subjects, endowing her novels with superior credibility. Mitchell's experiences treating Civil War veterans' neurological complications established his despairing attitude towards the War and provided the impetus for In War Time (1884). Herrick, himself disillusioned with the middle-class overemphasis on

and write, he was never formally trained in arts or letters. Woodress, op.cit., pp. 270-297 and Firkins, op.cit., pp.306-311.

⁵⁵Davis's father was a stern, poverty stricken, uneducated, alcoholic shoemaker. His father's business failures necessitated frequent family moves through multiple New York towns in search of their fortune. Schneider and Redfield, op.cit., p.105.

⁵⁶Lincoln was born on the Massachusetts Cape, the newest generation of a seafaring family. His father having died when Joseph was one year old, he was brought up by his maternal grandmother. Hough, op.cit., pp.460-461.

⁵⁷For two years, Lewis interrupted his undergraduate course and travelled across the United States. Martin Light, op.cit., pp.169-185.

material success, adopted this theme in several of his novels including The Healer (1911). Lewis peppered his life with an indefatigable wanderlust, settling in any one place for no more than a few years. Martin Arrowsmith's itchy restlessness was reminiscent of Lewis's own personal style. James Oppenheim modeled Dr. Rast (1910) after Dr. Felix Adler, a boyhood mentor.

The standards and ideals requisite towards becoming a good physician were not a timeless constant. Contemporary social, medical and scientific settings exercised their influence. Part of this study's goals is to recognize those fluctuating characteristics and their evolutionary trends. To adequately analyze this evolution, I divided the time period from 1859 to 1925 into four somewhat arbitrary but nonetheless coherent periods. Each novel was then appropriately catalogued given the novelist's perspective and frame of reference. The divisions are as follows:

1. 1859-1879: This period was marked by the American Civil War and the postbellum Reconstruction⁵⁸. Small towns in a primary rural, agrarian setting characterized American society⁵⁹. Medically, this period witnessed the final decline of depletive heroic therapeutics with the concomitant rise of experimental scientific research.

2. 1880-1893: This period was marked with the great urban migration. Both rural farmers and waves of immigrants crowded cities, creating increased demands on urban political and social establishments⁶⁰. These thirteen years

⁵⁸I selected H.W. Elson's History of the United States of America, (New York, McMillan Company, 1905) for a closer, contemporary account of the Civil War's events and the politics of the ensuing Reconstruction.

⁵⁹Robert H. Wiebe, The Search for Order: 1877-1920, (New York, Hill and Wang, 1968), p.2

⁶⁰Ibid., Ch.2 &3.

witnessed a full economic cycle-the booming 1880's followed by the crash of 1893⁶¹. American acceptance of the germ theory stimulated the development and application of diagnostic laboratory medicine. Antisepsis promoted surgical access of the abdomen. An equally active era in medical education, this period culminated with the founding of the Johns Hopkins Medical School.

3. 1894-1913: This period opened with the 1894 discovery of diphtheria antitoxin-the first definitive cure for a fatal illness. Popularization of the light bulb, telephone and automobile revolutionized the American standard of living and fundamentally affected medical practice. The hospital developed a niche, treating acute illnesses and providing sterile surgical environments⁶². The rise of the medical specialist began the process of specialty recognition.

4. 1914-1925: This period encompassed World War I and its immediate recovery. The War's outbreak stimulated a rapid decline in American attendance at German medical institutions and prompted the end of the American reliance on foreign medical institutions. Domestically, American medical education restructured in the post-Flexnerian era. By the 1920's, the United States shifted to a consumption economy, with the concomitant growth of mass marketing and advertising⁶³. Scientific developments including the 1921 discovery of insulin and its relation to diabetes stimulated the development in biochemistry, heralding the arrival of a fresh medical outlook.

⁶¹Ibid., p.22.

⁶²Starr, op. cit., p.157.

⁶³Vincent Vinikas, Soft Soap-Hard Sell: American Hygiene in the Age of Advertisement, (Ames, IA, Iowa University Press, 1992).

What follows is a brief plot synopsis for each novel. This includes both a plot summary and description of important characters-an outline of the 'materials' used for data collection. This section is meant to serve as a reference for the concrete evolution of each narrative and to eliminate the need to recapitulate these plots during the progression of the thesis's main arguments.

1. Elsie Venner [1859-Oliver Wendell Holmes, Sr. (1809-1894)]: Set in 1850's in a mid-size Southern New England town of Rockland, the novel elaborated on Elsie Venner, the seventeen year-old daughter of a wealthy widower. Affected since youth with a deep passionate nature, she possessed the reputation of a demonic charmer and suffered from multiple hysterical episodes and a generally fragile state of health. The novel described Elsie's eighteenth year, her year for emotional and romantic awakening. Unable to manage these new feelings, she ultimately fell victim to a stormy nervous collapse followed by premature death. Central to the novel are three physicians: Dr. Kittredge, the elderly town doctor, who served as primary physician to Elsie through her illness. Bernard Langdon, a young medical student, who spent a year teaching Elsie's class at the local girl's school and befriended the young lady. The Professor, an established physician at the prominent medical school where Bernard attended; Bernard maintained a correspondence with the professor throughout the novel.

2. Tale of a Physician [1869-Andrew Jackson Davis (1826-1910)]: The novel was set in 1850's, opening in New Orleans and then shifting to New York City. The physician, Dr. DuBois, is a general practitioner who has added some flavors of homeopathy to his therapy regimen. The story commenced in New Orleans where the physician was called to treat a mortally wounded army captain and then responded to his hysterical wife, Sofia. The novel then broke to carry the diverging stories of the Doctor, Sofia, and her estranged son, Carmo, a runner-lad for a band of thieves. The stories reconvened in New York City, where Dr.

DuBois, attempting to prove that all evil tendencies can be inherited in utero secondary to maternal disposition, studied Carmo's band of thieves as well as Sofia's shelter for troubled women. Throughout the novel, Dr. DuBois actively practiced medicine as well as carried out his research and crusaded against pregnancy termination. The important foil to Dr. DuBois was Dr. Morte, the local abortionist, whose practice set-up and style were carefully described.

3. In War Time [1884-Silas Weir Mitchell (1829-1914)]: Mitchell wrote this Civil War novel in 1884. The author, however, drawing from his own autobiographical role during the War, endowed the novel with striking realism⁶⁴. Mitchell immersed himself in the Civil War era, paying immaculate attention to detail. Both the physical setting and the depicted medical traditions most closely matched the 1860's standards. Consequently, this novel was classified with the first group of novels, covering the period from 1860-1879 rather than the 1880's group. Mitchell, like Holmes, was a physician and thus lent his professional insight to character development. The protagonist, Dr. Ezra Wendell, was a young, unmarried Massachusetts physician who moved to Philadelphia with his spinster sister to serve as a house physician for a local army hospital. At the hospital, Dr. Wendell acquired two private patients, Captain Grey, a Confederate soldier, and Major Morton, a member of the local haute bourgeoisie. Grey expired and Dr. Wendell assumed guardianship for his teenage daughter, Hester. Major Morton survived, and in continuing to follow

⁶⁴During the Civil War, Mitchell practiced in the Philadelphia army hospitals, caring for injured and amputated soldiers. In this capacity, he began his famed neurological research. As medical supervisor to an ambulance corps, Mitchell gained his first pass to the battlefield in July, 1863. The experience profoundly affected Mitchell's mental balance. Unable to erase that "strange complex odor which rises from a battlefield...as horrible and as like any other unpleasant smell", he suffered a nervous breakdown in 1864. As late as 1914, Mitchell continued showing the effects of his stressful summer. "His tales or poems, no matter what be their subject all come from a spirit over which had passed the great vision; every drop of ink is tintured with the blood of the Civil War". Wiegand, op.cit..

his convalescence at home, Dr. Wendell grew intimately acquainted with the Morton boys, Edward and Arty and the family's social circles. The novel chronicled Dr. Wendell's mixed personal/professional associations with both the Mortons and his new charge Hester. The narrative culminated with a malpractice case that ultimately led to Dr. Wendell's downfall. Throughout the novel, Dr. Wendell's practice style is contrasted with Dr. Lagrange, an established surgeon who served as Dr. Wendell's attending in the army hospital. Dr. Jones, the physician who assumed Dr. Wendell's practice also offered a counterpoint for comparison.

4. The Undiscovered Country [1880-William Dean Howells (1837-1920)]:

This novel, set in the period "some years ago when the rapid growth of the city was changing the character of many localities"⁶⁵, opened in Boston in circa 1880. Dr. Boynton offered his daughter Egeria as a séance medium to uncover a scientific basis for spiritualism. In the course of the evening, Boynton suffered irrevocable humiliation and accepted a friend's suggestion to depart for home and begin anew. On the homeward trek, Dr. Boynton, engrossed with eavesdropping on two Shakers' spiritualistic conversations, missed his connecting train northward. Both he and his daughter wandered penniless in the midst of an Upper New England snowstorm. The Boyntons were eventually rescued by the Shaker community and, while waiting for the daughter's convalescence, establish themselves in their community. The story traced Dr. Boynton's fascination with spiritualism, his devotion to the scientific method and his reidentification with the physician's creed. One other physician, Dr. Wilson, was introduced in a brief consultative role. The main focus was directed

⁶⁵William Dean Howells, The Undiscovered Country, (Boston, Houghton, Mifflin and Company, 1880), p.1.

toward Dr. Boynton's reawakening and his revitalized self provides an interesting foil to his initial portrayal.

5. Washington Square [1884-Henry James (1843-1916)]: This novel, set in 1880's New York City, catalogued the tribulations of Dr. Austin Sloper, an established local practitioner as he attempted to diffuse a romance between his only daughter Catherine and a young, loafing dreamer, Morris Townsend. Despite his efforts to prove the boy's worthlessness, he managed not only to alienate his daughter from society but left her with bitter remorse to thus eschew all future relationships. Although there were a few glimpses into Sloper's actual practice, his professional style was best conveyed through his strained relationships with both his daughter and his sister, Mrs. Penniman.

6. Doctor Sevier [1885-George Washington Cable (1844-1925)]: This novel, set in New Orleans between 1856 and 1872, is one of several that Cable has written to capture the life of a bygone era in the francicized state. Dr. Sevier (1885), like In War Time (1884), was set in a period different from the one in which it was written. However Cable's novel, unlike Mitchell's, was conceived during, influenced by and distinctly written from an 1880's perspective. Consequently, I have catalogued it among this second group of novels⁶⁶. Dr. Sevier was a local

⁶⁶In writing Dr. Sevier, rather than strive for historical accuracy, Cable attempted to explore the social context of human character and behavior patterns. Cable was renowned for his efforts at social activity and reform. Not only do many of his novels address issues of Southern post-Reconstruction reformation but he also established a program for social betterment in Northampton, Massachusetts, his home from the late 1880's. As he began to explore ideas for Dr. Sevier, Cable had recently completed reading one of William Dean Howell's works and was captivated by the latter's mastery of realism as a tool to depict abstract concepts. Hoping to employ the Howellsian style of realism in Dr. Sevier, Cable strove to present through the novel's characters the differing points of view of poverty, social station and human worth, the issues central to the novel. Unlike many of his other New Orleans novels which accurately detail the life and attitudes of a bygone time, Dr. Sevier is not preoccupied with its historical setting but the character issues already outlined. Arlin Turner, Introduction to Dr. Sevier, (New York, Garrett Press, Inc. 1970). Consequently, it would seem that, despite the historical setting, both the presented issues and the characters that embodied them most aptly reflected the 1880's than any other era.

obstetrician/gynecologist with an office situated in the New Orleans financial district. Called to attend Mary Richling's first miscarriage, he treated the patient. Frustrated by the Richlings, a well-meaning and refined but hopelessly unsuccessful and frightfully destitute young couple, he adopted their cause in an effort to improve their fortune. The novel, while chronicling Dr. Sevier's patrician relationship with the couple, provided a captivating description of postbellum New Orleans, its waves of new immigrants and the public health challenges spawned by the city's rapid growth. The novel also provided insight into all aspects of Dr. Sevier's practice, his interactions with patients from all strata of society and his professorial role at the local medical school.

7. Doctor Bryson [1904-Frank Hamilton Spearman (1859-1937)]: This novel was set in turn-of-the-century Chicago. Dr. Bryson was the twenty-eight year old surgeon-in-chief at the Laflin Eye and Ear Clinic, a world renowned center for ophthalmology and otolaryngology. Dr. Bryson met boarding-house mate Mrs. Eliot, a separated, single mother whose daughter was rapidly losing her sight, after the latter was denied appropriate consultation by a clinic colleague. Dr. Bryson not only cured the daughter but established a deep romance with Mrs. Eliot herself. The novel described Dr. Bryson's courtship of Mrs. Eliot which was confounded by the lady's fears of the stigmata of divorce. The romance climaxed when Mrs. Eliot developed hysterical amblyopia upon her husband's death. The novel also elaborated on two other physicians: Dr. Kurd, the social-climbing, status-seeking ophthalmologist who initially dismissed the Eliot consult and an old country physician who treated Dr. Bryson during a bout of pneumonia he contracted while vacationing in the midwestern hinterlands.

8. Doctor Rast [1909-James Oppenheim (1882-1932)]: This novel described the New York Lower East Side in 1909; the clamor of newly arrived Eastern European Jewish immigrants' tenements. Dr. Rast, an American-born Jew,

educated at Columbia P. & S., had chosen to practice in this impoverished area of town to facilitate the difficult transition to the American way of life. The novel opened with the author asking for Dr. Rast's permission to chronicle his life's work as a testimonial to the life and times of a doctor working in the otherwise anonymous Jewish ghetto. What followed was a series of vignettes outlining the Doctor's struggles with an impoverished, overpopulated community who still managed to display an overwhelming zest for life. The novel focused not only on Dr. Rast's medical heroics but also on his day to day struggles of renewing his commitment to this community. Highlighted was the conflict of maintaining a harsh urban practice while beckoned by plush suburbs. The novel also provided provoking exchanges between Dr. Rast and both a young medical student and a former classmate who has devoted his career to basic research in therapeutics.

9. The Healer [1911-Robert Herrick (1868-1938)]: This novel was set primarily in the northern tier of the Eastern United States, at the frontier of civilization. Opening at a relatively isolated summer resort situated on the edge of the timber line, the story shifted to an anonymous big city. The time setting commenced in the fin-du-siècle and passed through the next twenty years. Frederick Holden, M.D. was a prominent neuro- and general surgeon who, in his late twenties, grew tired of the politics and social-climbing of medical academia. He retired to the edges of the woods to live off the land and provided basic general practice to local Native Americans and the logging industry's unfortunate peons. Dr. Holden's peace was interrupted when a guest at a nearby summer cottage smashed her head against a rock while diving and suffered a subdural hemorrhage. His expertise was required to save the girl's life. Dr. Holden drew his therapeutic sagacity from his magnetic charm augmented by the local lake's 'healing powers', a regional Indian tradition. Dr. Holden married his beguiled patient and together they built a healing spa around the spring. As the region

itself was further developed, Dr. Holden increasingly bowed to the pressures of his cosmopolitan wife until the spa precisely represented medicine's commercial aspects he desperately tried to escape. Leaving his wife and burning the spa, Holden fled to the bowels of the city's working class to rekindle his lost spirit. The novel introduced several other physicians as secondary characters: Dr. Percy Farrold, the timid neophyte fresh out of medical school who grows into a devoted rural practitioner; Dr. Jenks, the talented urban surgeon; Dr. Holden's former classmate, now a struggling basic scientist; and Dr. Farrington, the established, polished general practitioner whose practice success was based more on personality than talent.

10. The Career of David Noble [1921-Frances Parkinson Keyes (1885-1970)]:

This novel opened in Southern Vermont to introduce David Noble, an unusually bright fourteen year-old from 'out back' in the woods with the singular desire to be a world-class surgeon. David obsessed about his career goals such that he shut out all outside distractions including emotional involvement with both his family and Jacqueline, the displaced French orphan who initially befriended then fell in love with David as they matured. After having graduated from medical school and having established himself in a powerful apprenticeship/internship, David embarked for Europe to pursue a surgical fellowship and to claim Jacqueline. David's subsequent catastrophic social blunder broke the engagement and flung Jacqueline beyond his grasp. All that remained was a promising surgical career as a prominent Boston clinic's Chief Surgeon. David subsisted emotionally unsatisfied. In a bold move, David took leave of Boston and headed out to rediscover his lost love. While scouring the French countryside, he accidentally ran over Jacqueline with his motorcar. In his ensuing labor to restore her health, he discovered a new dimension to medical practice and patient care. Ultimately, he redirected his previously unalterable

career directive. David's bedside manner was contrasted to that of 'monsieur le Médecin', the quiet family practitioner in the French town of Fleursy; to Dr. Bobby Hutchinson, a general practitioner from Boston; and to Dr. Ross, his elderly mentor, a world-renowned surgeon and founder of the Ross Surgical Hospital.

11. Doctor Nye of North Ostable [1923-Joseph Crosby Lincoln (1870-1944)]:

This novel was set in the 1920's on the Massachusetts cape town of North Ostable. The story chronicled the return of Dr. Ephraim Nye to Ostable, his home town, after having served an eight-year prison sentence. He had been tried and convicted of grand larceny for having robbed the Ostable public coffers. The novel focused on Dr. Nye's struggle to regain the reputation he possessed prior to the trial. Dr. Nye slowly rebuilt his practice by providing medical attention to the impoverished Portuguese community who otherwise received no medical care. His most powerful nemesis was Judge Copeland, the town magistrate and Dr. Nye's brother-in-law. Dr. Nye was first thrown face to face with Copeland when his daughter crashed her motorcar on Nye's fence post. The ensuing injury's severity necessitated complete immobility; convalescence in Dr. Nye's very own house. Dr. Nye increased his notoriety by challenging Ostable's selection of Hallett's Pond for a city water source. Concerned about the source's possible contamination with typhoid bacteria, Dr. Nye openly campaigned against Ostable's 'establishment'. Mrs. Powell, a concerned, socially active wealthy widow joined the cause and legitimized his crusade. This working relationship rekindled the couple's romance of twenty years' previous. Dr. Parker, the established elderly town physician depicted a more conservative, 'old-boy', professional demeanor which was often directly juxtaposed onto Dr. Nye's style.

12. Arrowsmith [1925-Sinclair Lewis (1885-1951)]: This novel detailed the life story of Martin Arrowsmith as he navigated through medical school and then tried to establish himself in various branches of the medical profession. Although the novel opened in the early 1890's and then chronicled Dr. Arrowsmith's next thirty years, the perspective throughout the novel portrayed 1925. This was reflected in Lewis's post-Flexnerian attitude towards medical education, Progressivism towards public health and hygiene⁶⁷ as well as the invocation of private endowments to fund basic science research. The novel began with details of Dr. Arrowsmith's youthful fascination with medicine followed by his trials at Winnemac State University through both a Bachelor's degree and medical school, including two years of postgraduate internship at the local hospital. Arrowsmith then embarked on establishing a medical career and tried many clinical hats. His efforts spanned the entire medical profession: a rural general practitioner, assistant to chief of local department of Public Health, pathologist to a large private surgical clinic, principal investigator of a scientific laboratory, department chair at an endowed research institute and finally field investigator and primary health provider to a third world community besieged by bubonic plague. The novel also delved into Dr. Arrowsmith's personal life and the bi-directional effects between it and his professional aspirations. At each juncture, as Dr. Arrowsmith grew increasingly dissatisfied with the

⁶⁷In the 1920's, the cult of advertising established itself in American society. Personal hygiene products, like all goods, were manufactured in surplus. Creative advertisers then concocted new teases to market the products. In the 1900's personal hygiene consisted of the 'Saturday bath', rare diurnal toothbrushing and no deodorants and mouthwashes. During the following two decades, soap manufacturers stimulated general public health and hygiene awareness in efforts to peddle their products. In public schools, children were taught the 'virtues' of frequent toileting and that violating these principles compromised not only themselves but others around them. Advertisers frequently recruited physicians to offer expert testimonials, hoping to create a product's sense of vogue. Fuelled by the advent of indoor plumbing, these efforts towards increasing public hygiene served to increase the tolerability of close quarter city living. Vinikas, op.cit. pp.14, 87.

commercialization and politics of each task, he quested for a solitude free from external demands where he might continue his scientific pursuits undisturbed. Ultimately, he abandoned society altogether and headed to join his scientific companion at an isolated Vermont cabin and achieved his separate peace.

In addition to the title character, the novel paraded a cast of physicians and scientists. Max Gottlieb, M.D., a German immigrant who studied experimental medicine in his home country and had devoted his life to characterizing the physical chemistry of antibody reactions epitomized the scientific investigator. Prominent characters also included Angus Duer and Irving Watters, two of Dr. Arrowsmith's medical classmates who proceeded towards careers in general surgery and private internal medicine practice, respectively; Almus Pickerbaugh, the politicking director of the Nautilus Board of Health; Gustaf Sondelius, the fiery Swede who crusaded in the trenches while fighting epidemics; and Terry Wickett, the rogue scientist at the McGurk Institute who espoused a distaste for political claptrap even stronger than Martin's. Also featured are Doc Vickerson, the alcoholic family practitioner of Martin's hometown, Reverend Ira Hinckley and Fatty Pfaff, two additional classmates; Drs. Davidson and Geake, clinical professors of Winnemac Medical School and Dr. Silva, its dean; Drs. Winters, Hesselink, Coughlin and Tromp, local Wheatsylvania practitioners; Drs. Tubbs and Holabird, directors of the McGurk Institute; Dr. R.E. Inchcape Jones, Surgeon General, and Drs. Stokes and Marchand, practitioners on the island of St. Hubert.

CHAPTER 1: EDUCATING THE GOOD PHYSICIAN

Mid-nineteenth-century medicine, while considered a liberal profession⁶⁸, also required its students to apprentice for several years under a local practitioner's supervision to master practical skills⁶⁹. This unique demand for both practical dexterity and academic prowess directed American physicians to pay particular attention towards their own education. A physician's medical training rested at the cornerstone of his professional identity.

American medicine's educational foundation was laid in 1765 when John Morgan established the first American medical school at the College of Philadelphia (later University of Pennsylvania)⁷⁰. The advent of medical

⁶⁸In his essay "Classics and Character: Medicine and Gentility", Gert Brieger explained how medicine was regarded as a 'liberal profession'; one which required prerequisite training in the liberal arts prior to matriculation into the profession. Two forces drove this trend. Firstly, practicing physicians considered it essential that aspiring physicians be able to prove their moral worth. Successful completion of a sound, rigorous education in the classics seemed to indicate appropriate character mettle to warrant admission for a course of medical study. The second motivation came from the students themselves. Up on through the turn of the century, the only respectable career avenues available to 'college' men following graduation included law, the clergy and medicine (business and commerce were only gaining marginal respectability following a college education). Collegians not admitted to law or divinity faculties were shepherded into medicine and brought with them a classical background. Consequently, although a formal undergraduate degree was not universally required until the passage of the Flexner report, physician educators were most eager to enroll students with some degree of formal training in the classics. Brieger, Classics and Character, pp.94-98.

⁶⁹ Apprenticeships were most popular in the early nineteenth century, when most physicians received their education from by pursuing a three-year course with a physician-preceptor. Under the physician's auspices, the student assumed graded responsibilities. He typically began with reading texts and preparing therapeutic mixtures, progressed through basic nursing and wound care management and culminated by escorting the physician on patient rounds and assisting in minor surgeries. Although by mid-century, students often requested attendance at medical school to gain exposure to the growing medical knowledge base, the apprenticeship remained a favored part of medical training. Not only were there economic incentives for both parties (physicians received a cheap source of skilled labor, while apprenticeship fees were substantially less than formal tuition fees), students enjoyed the intimate contact with their revered role models. Rothstein, op.cit., pp.85-87.

⁷⁰ Stevens, op.cit., p.16.

education to the United States opened the profession's avenues towards self-determination. Aspiring American physicians no longer needed to travel abroad to Europe to receive formal training in medical arts and sciences. By 1800, the United States boasted four equally competitive medical schools⁷¹. These produced competent physicians able to treat the burgeoning local population. American medical education became a plausible alternative to studying in Europe⁷². The medical profession envisioned creating an educational and professional infrastructure that would rival England's⁷³.

These pioneers, however, produced a convoluted, disorganized system that would take almost a century to reorganize⁷⁴. By the 1810's, the Jacksonian Era destroyed all dreams and possibilities of a British-styled system. The essence of Jacksonianism embodied free, open competition amongst all Americans⁷⁵.

⁷¹Schools were founded in Pennsylvania, Columbia (then King's College), Dartmouth and Harvard. Of note, Yale's institution was founded in 1813 but the latter institution has the dubious honor of bestowing the first American medical degree, an honorary title given to Daniel Turner in 1720. Ibid., p.19.

⁷²Following the Revolutionary War, the consolidation of European and Philadelphia trained physicians with army militia-trained commissioned surgeons burgeoned the American medical profession. Nuclei of qualified professionals could be found in most American cities. The feelings of both national and professional unity and strength gave the American medical profession a sense of independence and the ability to establish indigenous professional roots. Ibid., p.22.

⁷³Starr, op.cit., p.30.

⁷⁴Morgan's goal was to establish in the colonies the British system of two-tiered medicine. While it would be sufficient for the American equivalent of the apothecary to simply undergo an apprenticeship, additional, formal university training would be necessary to be recognized as a consultative physician. Morgan felt that only a physician trained in medical theory could fully appreciate disease phenomena; the differential between the simple tradesman and the qualified professional. Lester S. King, "Medicine in the USA: Historical Vignettes II. Medical Education: The Early Phases", *JAMA*, vol. 248 (1982), pp.731-734.

⁷⁵The pattern of Western migration best captured the Jacksonian spirit. The endless opportunities of the open frontier beckoned to any individual with sufficient initiative to pack his gear and move Westward. Nature was the great equalizer. Any man, irrespective of his previous social position, could establish his worth by surviving the challenges of forging a new trail. This philosophy transcended throughout the Jacksonian age of optimism nationalism and pride. All Americans,

The American medical profession suffered many repercussions from the Jacksonians' general campaign against all forms of elitism. Specifically, open competition spurred the rise of the proprietary medical school-small, private medical colleges boasting no affiliation to a liberal arts institution⁷⁶. Professional leaders recognized from the outset the inferior education offered in the proprietary institution. Jacksonian ideals, however, paralyzed them from setting minimal educational standards. "The patient was to have the right to make his free choice between the trained and the untrained"⁷⁷. Any restrictive legislation would compromise the patient's freedom of choice. Furthermore, anti-elitist sentiments handicapped the physician from setting his own professional standards. Proprietary schools proliferated. By the Civil War their graduates formed the majority of practicing physicians. The proprietary graduate's educational unpredictability unsettled the already insecure regular profession⁷⁸

It was during the period between 1859 and 1925 that the American medical profession launched regular medical education into the forefront of its quest for professional authority and integrity. Already, academic qualifications distinguished the regular profession. By the 1850's, regularly graduated physicians were automatically granted medical licensure and admission to medical societies; apprenticed physicians required an additional examination. Medical sectarians, despite possessing the M.D. degree, were dismissed on the

regardless of social or economic status, should begin life with identical opportunities for success. Stevens, op.cit., p.26.

⁷⁶Proprietary school graduates filled an important niche. Typically founded in sparsely populated regions nearer to the Western frontier, they supplied these rural areas with much needed physicians. Ibid., p.25.

⁷⁷Ibid. p.25.

⁷⁸Ibid. p.28.

basis of their differing educational plan. The AMA's 1847 charter promised to revoke regular physician licenses should they consult irregular practitioners and further denigrated the sectarians.

Yet, the regular profession's rally behind its educational platform created an equally fruitful source of tension as one of unification. As the medical profession matured from 1859 to 1925, new internal struggles perpetually emerged. Standardizing regular medical education proved to be an enormous task. With the increase in experimental scientific discoveries, frequent heated debates emerged arguing the extent to which these new theories should be incorporated into the medical curriculum. Advances in clinical diagnosis and therapeutics stimulated similar challenges. As undergraduate medical education grew more focused and lengthy, the issue of requiring preparative premedical and additional postgraduate training erupted. The development of specific technical skills requiring precise expertise spawned the factions favoring medical specialization and challenged the generalist's rights to learn and perform these 'specialized' procedures⁷⁹. Through all these growing pains, one question equally nagged the medical profession and its patients: how might these changes affect the caliber of the good doctor. Were these alterations poised to raise the standard of good doctoring or did they detract the physician down a tangent and concomitantly hurry some preferred traits into obsolescence.

To analyze medical education's evolving role in creating the good doctor, I have selected two issues highlighted in the literary texts: the educational

⁷⁹This dual identity was perhaps one of the most straining aspects among physicians. Dating back to colonial times, from the founding of the United States' first hospital there were strained relations between physicians with formal training in arts and letters and those who gained their education mostly by apprenticeship with marginal appreciation for the classics. This debate persisted throughout the history of American medicine and eventually evolved into the struggle between generalist and specialist. *Ibid.*, p.18.

pathway and the curriculum's content. The second category has been further subdivided to deal independently with issues of the American curriculum, the European influence. These topics exemplified the impact of medical education's upheaval on the criteria, expectations, performance and qualifications of the good doctor.

I. The Educational Pathway

The core of the American medical profession's struggle for professional identity focused on who should bear the title 'doctor'. In Britain, the professional titles were as rigidly regulated as were aristocratic peerages⁸⁰. On American soil, a different situation persisted. In colonial times, physicians often engaged in additional professional pursuits⁸¹. The boundaries demarcating the medical profession blurred and blended with the balance of American society.

Exposed to European professional autonomy and dignity, American physicians returning from studies abroad sought to reorganize their own

⁸⁰Britain espoused a two-tiered system organizing the medical profession. The physician rested alone at the top. In England, the M.D. degree could only be obtained from Oxford or Cambridge and substantial premedical preparation was required for gaining admission. Edinburgh offered easier standards for the degree. Further campaigning was required for acceptance into London's elitist Royal College of Physicians. Apothecaries and surgeons, functioning as subordinate practitioners, comprised the second tier. The learned physicians tended the rich; surgeons and apothecaries, lacking extensive medical knowledge, ministered the poor. Apothecaries, ranked lowest, were relegated as the physician's assistant. They prepared and dispensed physicians' prescriptions. Nonetheless, they also enjoyed specific privileges. They could offer free medical advice and sell appropriate remedies without physician intervention as well as perform minor procedures such as blood-letting and lancing. Lester S. King, "Medicine in the USA: Historical Vignettes I. The British Background for American Medicine", *JAMA*, vol. 248 (1982), pp.217-220. For a more elaborate discussion, see Irvine Loudon's Medical Care and the General Practitioner (Oxford, Clarendon Press, 1986).

⁸¹Paul Starr catalogued the employment pursuits of several colonial health care professionals. One surgeon also sold wigs. A druggist also sold nonpharmaceutical dry goods and fresh produce and a Mrs. Hughes advertised that she practiced midwifery, cured ringworms, scald heads, piles, worms, and made ladies' dresses and fashionable bonnets. In addition, many colonial American physicians were either ministers or engaged in public office. Starr, op.cit., pp.39, 40.

professional structure to emulate the European model. The United States, however, evolved a one-tiered system that legally recognized all licensed physicians as equal, irrespective of training or qualifications. No Royal College of Physicians separated the formally trained physician from his less educated colleagues⁸². By the 1830's, vehement debates arose about the relative qualities of the various American medical teaching institutions. Formally-educated physicians challenged apprenticeship comprehensiveness⁸³. Nonetheless, many practicing physicians opposed the rapid proliferation of medical colleges⁸⁴. Physicians yearned for controlled medical school regulation, and suggested implementing the European system that featured a three- to four-year course with high preliminary requirements, long terms and exhaustive graduation requirements⁸⁵. Critics indicated, however, that these standards could only be executed in a wealthy society able to support its students' academic pursuits. They still regarded the United States as a poor society; an elaborate educational program as suggested would drive many poor aspiring physicians to skip school

⁸²King, Vignettes II, pp.731-734.

⁸³Famous nineteenth century physicians, including Charles Caldwell and J. Marion Sims, cited inadequacies in their apprenticeship experiences. Their teachers, although talented clinicians, had "no library, no apparatus, no provision for improvement in practical anatomy, nor any other efficient means of instruction in medicine". Preceptors also had no means for keeping up with medical advances filtering in from Europe. In addition, many preceptors were not master diagnosticians; the educational quality was highly variable and licensing boards often had no methods of verifying a student's competence. Physicians regarded their apprenticeships as wasted time and jumped at the prospect of attending medical lectures. As medical schools proliferated, many established physicians took the opportunity to enroll and receive didactic training in the sciences. Rothstein, op.cit., pp.102-103.

⁸⁴In the 1830's to the 1850's medical journals published repeated forebodings about the medical profession's potential decline due to the medical colleges' self-serving manoeuvres. Physicians, mostly fearing the rapid increase in competition from the ensuing surge in medical graduates, claimed that merely receiving the M.D. was an inadequate qualification for automatic licensure. Ibid., pp.106-107.

⁸⁵Ibid., p.110.

altogether and practice as empirics⁸⁶. The contemporary situation already provided many loopholes to minimize actual educational effort⁸⁷. Any further compromise was viewed as potentially disastrous.

Deciding the optimal pathway to create the properly trained doctor continued to generate factions within the medical community. As new pathways and options were established, the medical community hotly debated their usefulness and validity before deciding to keep or drop the new method. This process, especially prominent between 1859 and 1925 was illustrated in the twelve novels. The novels frequently offered each physician's educational pathway as background justification for his soundness or incompetence in practice. In each period, the author focused on particular aspects of physician training to bolster his characters. This section highlights the salient issues motivating the emphasis of specific educational pathways as the good doctor's appropriate training.

In the 1860's, the medical student had several distinctly divergent options in obtaining his education. The student could follow the classical pathway and apprentice for three to six years with an established physician. Conversely, he could enroll in one of the regular medical colleges-academic or proprietary- with or without a previously acquired liberal arts degree. Finally, he could opt to pursue one of the sectarian programs, which at that time included Homeopathy

⁸⁶Rothstein, op.cit., p.110, and King, Vignettes VI, pp.731-734.

⁸⁷In the 1850's, students could actually progress through medical school with relatively little effort. Minimalist exams ensured that students passed courses with only rare class attendance. Transcripts were not produced. A student's only receipt was his tuition receipt; the admission ticket. Upon transferring medical colleges, students simply presented cancelled admission tickets to prove they completed coursework. Despite the inability to verify satisfactory mastery, students were nonetheless exempted from repeating coursework at their new colleges. By frequently changing schools, students could waive most academic graduation requirements. King, Vignettes VI, pp.731-734.

and Eclecticism⁸⁸. The post-Jacksonian era of medicine, however, differentiated between each type of physician. Only those candidates receiving their M.D. from a regular medical school automatically qualified for medical licensure. The apprenticeship's random quality challenged its validity. Sectarians, indiscriminately labeled as quacks, practiced independently and outside of the regular profession. The 1860's novels supported the quest for professional identity and emphasized the priority to obtain a school-based regular medical education.

Bernard Langdon, depicted in Elsie Venner, followed a typical course towards becoming a regular physician. He enrolled for one year at medical school, took a two year sabbatical to teach grammar school to financially support his medical aspirations (his father's estate did not provide sufficient funds to cover the cost of medical education⁸⁹) and then finished his last year of school, presenting a thesis upon graduation. Bernard's course was instrumental in his future career's success. He not only "had no sooner taken his degree, than, in accordance,...he took an office in the heart of the city in which he studied"⁹⁰ but also by the age of twenty-three was offered full professorship at an ancient university⁹¹. Furthermore, in pursuing this successful plan, it was unlikely that Bernard engaged in any formal premedical training. To account for the five years

⁸⁸Homeopathy was founded by Samuel Hahnemann in Germany in the last decade of the eighteenth century. Hans Gram, an American Dane, after sojourning in Europe, brought Homeopathy to the United States in 1825. Lester S. King, "Medicine in the USA: Historical Vignettes III. Medical Sects and Their Influence", *JAMA*, vol. 248 (1982), pp.1221-1224. Eclecticism, a botanical sect, evolved out of Thompsonianism in the 1850's. Starr, op. cit., p.96.

⁸⁹Oliver Wendell Holmes, Sr., Elsie Venner: A Romance of Destiny, (Boston, Houghton, Mifflin and Company, 1891), pp. 15-16.

⁹⁰Ibid., p.482.

⁹¹Ibid., p.485.

covered in the novel prior to his having received his professorship, Bernard had to have enrolled in medical school prior to the age of eighteen. He most likely bypassed a liberal arts collegiate experience.

The only hints at Dr. Wendell's formal education in In War Time (1884) is that "he had shown promise at school...in a career at school or college it is possible to 'catch up',...his first failure was as a teacher,...then he studied medicine and was so carried away by the intellectual enthusiasm..."⁹². Dr. Wendell definitely attended a regular medical college; only a collegiate atmosphere afforded the student exposure to medical theory, its cornerstone coursework. Further insight into his formative training was lacking. Dr. Wendell's student-role is nonetheless captured through his work as a "contract-assistant surgeon"⁹³, a junior surgical houseofficer, for a Philadelphia military hospital charged with wounded Civil War soldiers. At this hospital, Dr. Wendell was responsible to follow patients on the wards, a "vast hall...filled with long rows of iron bedsteads, each with its little label for the owner's name, rank, disease and treatment suspended from the iron crossbar"⁹⁴, the equivalent of a present-day 'intern'. Dr. Wendell functioned in a subordinate role, reporting patient progresses to attending surgeons on rounds, as evidenced by Dr. Lagrange's greeting of a new patient: "well, well, we shall give you a health brevet soon...take good care of Major Morton, Dr. Wendell. He is an old friend of mine"⁹⁵. Dr. Wendell never operated or carried out other senior attending

⁹²Silas Weir Mitchell, In War Time, ed. by William Wiegand (Albany, NY, NCUP Inc., 1990), p.11.

⁹³Ibid., p.2.

⁹⁴Ibid., p.5.

⁹⁵Ibid., p.5.

duties, reinforcing his position of student and apprentice to these accomplished surgeons. In War Time (1884) clearly supported the perspective requiring sound practical training as an apprentice in addition to collegiate training. Whereas Dr. Wendell had grossly succeeded in the classroom, "in the school of life, there are no examinations at set intervals; and success is usually made up of the sum of happy uses of multiplied fractional opportunities"⁹⁶. A rigorous practical training was classified as essential exposure to determine a student's mettle and capacity for assimilating a rigorous medical practice's taxing requirements.

Tale of a Physician (1869), unlike its two contemporary novels, was written by a layman and offered a less biased perception on recommended physician training. Dr. DuBois, like Drs. Langdon and Wendell attended a regular medical college. However, Davis himself practiced spiritualism and chose to supplement Dr. DuBois's regular studies with both homeopathy and mesmerism⁹⁷. Having "graduated in Paris, [he] owned a diploma which had been richly earned by hard and diligent study" but "he was partially a convert to that more refined and scientific practice [homeopathy] and had experimented with the infinitesimal agents to some extent in the treatment of yellow and bilious fever"⁹⁸.

Dr. DuBois's emphasis on his regular academic diligence reinforced his primary allegiance to the regular profession with irrefutable credentials; he was not a sectarian. However, his integration of specific sectarian ideals into his regular framework suggested that practicing quality 1860's medicine required the

⁹⁶Ibid., p.11.

⁹⁷Andrew Jackson Davis, Tale of a Physician or The Seeds and Fruits of Crime, (Boston, William White and Company, 1869), p.34.

⁹⁸Ibid., p. 37.

flexibility not only to learn the tenets of multiple therapeutic ideologies but also how to blend each of these into a single, solid practice⁹⁹.

Up through the 1880's, the compendium of educational options suffered only minor alterations. Most notably, as various sectarian practices peaked then gradually fell out of favor, the trend to incorporate these into regular medical practice followed suit. Regular medical education, despite many efforts¹⁰⁰, remained remarkably unchanged. The core educational programs stabilized at requiring formal regular didactic classes succeeded by exposure to clinical practice, either incorporated into the medical curriculum or as a post-graduate apprenticeship¹⁰¹. Licensing laws through the 1880's reflect the importance of attending medical classes; by pursuing the classic path of a simple apprenticeship,

⁹⁹ Perhaps it is to DuBois's credit that he adopted some of the gentler practices of homeopathy since these were more popular among the sick public who were loathe to purging and other heroic regular therapeutics which further aggravated their malaise. Stevens, op.cit., p.21. Also, his having a regular medical diploma allowed him to receive consults from other regular physicians without their being in contempt of the AMA regulations. Lester S. King, "Medicine in the USA: Historical Vignettes IV. The Founding of the American Medical Association", *JAMA*, vol. 248 (1982). pp.1749-1752.

¹⁰⁰ Since 1849, groups of American educators lobbied to increase both the standards of premedical education and the content of medical education. Each proposition, however, was vehemently debated and ultimately dismissed. By 1877, a few schools followed Harvard and adopted its 1871 reform, [Huddle, op.cit., pp.340-365], but the overall national situation had deteriorated and echoed the identical problems identified thirty years previous. Proprietary medical school professors received chastisement formerly reserved for apprenticeship preceptors. These inferior schools lacking adequate facilities and rigorous training requirements stocked the profession with poorly trained physicians. Not only was the profession overburdened but the public had no recourse to recognize the chaff. However, movements to restrict proprietary schools were halted, supporting the rising need for less eloquent but practically competent physicians to cover the commonest, basic medical complaints. Lester S. King, "Medicine in the USA: Historical Vignettes VII. The Painfully Slow Process in Medical Education", *JAMA*, vol. 249 (1983), pp.270-274.

¹⁰¹ Clinical Laboratory skills were introduced and integrated into medical education beginning in the 1880's. Medical schools expanded clinical instruction beyond the traditional amphitheatre demonstrations of sick patients. In 1882, the New York Polyclinic, one of the first American clinical postgraduate institutions opened. These clinics, however, never gained the prestige of their European counterparts and quickly refocussed their energies towards advanced specialist training rather than expanding generalist skills. Robert P. Hudson, "Abraham Flexner in Perspective: American Medical Education 1865-1910", *Bulletin of the History of Medicine*, vol. 65 (1991), pp.545-561.

it was increasingly difficult to obtain full licensing¹⁰². For the academically oriented student, several new options were added¹⁰³. Two events, catalyzed by "industrialization, immigration, increasing urbanization, the gradual closing of the frontier, the spectacular growth of scientific concepts"¹⁰⁴ converged in the 1890's and ultimately redefined the educational requirements inherent to creating the good physician.

The 1893 founding of the Johns Hopkins Medical School was the pivotal event in the undergraduate medical curriculum's reorganization¹⁰⁵. Concurrently, the establishment of Graduate degree programs in experimental

¹⁰²In 1869, the AMA adopted a resolution supporting that state medical societies exact from every licensing candidate adequate proof that he has "a proper general education, is twenty-one years of age, and has pursued the study of medicine three full years, one year of which time shall have been in some regularly organized medical college, whose curriculum embraces adequate facilities for didactic, demonstrative, and hospital clinical instruction...all persons who...seek to enter upon the practice of medicine without first receiving a license from some State Board of Examiners, shall be treated ethically as irregular practitioners". Fishbein, op. cit., p.1012.

¹⁰³By the 1880's, some 40% of medical students had completed baccalaureate programs prior to matriculating in medical school. In considering medical education itself, Harvard adopted its reform package in 1871 lengthening and broadening its curriculum. After two years of faltering enrollment, the new program carved out a niche among students interested in pursuing trends in experimental medicine imported from Germany. By 1877, the University of Pennsylvania, the University of Michigan and Syracuse University adopted the Harvard plan. The Morrill Act of 1862, establishing public high schools, broadened the opportunities for the poorer student to obtain premedical training. Hudson, op. cit., pp.545-561; King, Vignettes VII, pp.270-274; Huddle, op.cit., pp.340-365.

¹⁰⁴ King, Vignettes VII, pp.270-274.

¹⁰⁵With its founding, Johns Hopkins Medical School enforced radical but effective policies. It centered educational programs around the patient and laboratory facilities. It did not attempt to recuperate the growing expense of medical education exclusively from student fees. It established full-time, salaried professorships in both clinical and research fields. It created a four-year graded undergraduate medical curriculum. It also upgraded entrance standards-benefactors stipulated their donations on requiring all matriculants to possess a baccalaureate degree from a four-year college, having fulfilled specific premedical requirements. recognized that the growing expense of medical education. Unlike any previous efforts at educational reform, the Johns Hopkins plan sparked national attention. Stevens, op.cit., pp.56-57.

sciences entrenched laboratory research into the medical institution¹⁰⁶.

Ultimately, the Johns Hopkins infrastructure would be adopted as the regular profession's educational Gold Standard¹⁰⁷. Internal tension arose within the medical profession, resulting from acceptance of the Johns Hopkins innovations. By declaring the Johns Hopkins program as superior, the corollary suggested that schools who did not adopt these exacting standards were decidedly inferior.

Proprietary educators were particularly enraged.

Proprietary schools' popularity and numbers peaked in the 1880's. These schools had adopted a particular niche. Their goal was not to produce scientifically-minded physicians but to churn out 'practical' physicians able to provide basic care for the general population¹⁰⁸. These programs were solely financed through students' tuition payments. The new pressures to adopt and incorporate modern laboratories, libraries and clinical institutions drove operation costs beyond most proprietary schools' modest budgets¹⁰⁹. These

¹⁰⁶In the 1850's, Yale pioneered university graduate education. Rensselaer Polytechnic Institute dated graduate course offerings in scientific fields from the same time. Harvard established theirs in the 1870's, using the German institution as a model. These programs were minorly successful. The Johns Hopkins graduate curriculum launched the Ph.D.'s success. Stevens, op. cit., p.56. Reflecting on the Ph.D.'s newly found niche, the first Johns Hopkins president Daniel Coit Gilman stated: "the degree of Doctor of Philosophy may be won by advanced work in the most remote languages of the past or in the most recent developments of biology and physics". Brieger, Classics and Character, p.104.

¹⁰⁷In 1908, the AMA Council on Medical Education joined forces with the Carnegie Foundation for the Advancement of Teaching and selected Abraham Flexner to inquire into medical education's intricacies. Flexner visited each medical school and published his report in 1910. Only Harvard, Case Western Reserve and Johns Hopkins received perfect honors. Moreover, Flexner took Johns Hopkins's system as a model and suggested that all school incorporate a full-time staff, laboratory and hospital facilities as standard components for solid medical education. Stevens, op.cit., pp.66-67.

¹⁰⁸King, Vignettes VII, pp.270-274.

¹⁰⁹Starr, op. cit., p.118.

pressures¹¹⁰ resulted in the closure of ninety-two schools between 1904 and 1915¹¹¹.

The selected twentieth-century novels reflected the emergence of the Hopkins-esque program as the preferred educational option. By the 1900's, the distinction of having trained in a regular medical institution was insufficient criteria to qualify as a good physician. The good physician became distinguishable only through the type of regular education he received: attendance at a university-affiliated, four year graded program with emphasis on basic and clinical sciences.

The Healer emphasized the importance of a physician's educational credentials in acquiring community respect and confidence as a fin-du-siècle good doctor. Despite the prelude that Dr. Holden had "a great reputation up here [in remote logging country]", the vacationing summer community envisioned that only a "greasy herb doctor most likely"¹¹², practiced in such remote areas . They assumed that since university-based training was highly recommended in procuring a respectable urban position any medic lacking this background could only obtain employment in the nation's backwoods. Mrs. Goodnow, in her search for a good doctor, was unwilling to acknowledge any physician missing this highest echelon of medical training, a degree from a Hopkins-styled

¹¹⁰The last nineteenth-century decades' graduating classes glutted the United States with an overabundance of marginally mediocre physicians. Many physicians struggled to gain a reasonable income. Hudson, op. cit., pp. 545-561. Potential students were consequently dissuaded from enrolling in training programs. In the face of declining quantities of matriculants, proprietary schools were acutely aware of their tenuous existence. Lacking the paraphernalia of expanding medical campuses, they bitterly fought to attract enough students to meet their budgetary requirements. Starr, op. cit., p. 118. The Flexner Report only aggravated the situation by reporting their unflattering condition- "very weak", "dirty", "miserable", "utterly wretched" and "containing nothing that can be dignified by the name of equipment". Stevens, op. cit., p.67.

¹¹¹Stevens, op. cit., p.68.

¹¹²Robert Herrick, The Healer, (New York, The MacMillan Company, 1912), p.5.

undergraduate medical program. Dr. Holden's reputation was salvaged only by Dr. Percy's rejoinder that he "has seen him and says that the man has had training, is a graduate of a good school"¹¹³. Dr. Holden's reputation hinged on the confirmation of his possessing solid educational criteria.

Doctor Rast's medical training also verified his standing as a good physician. Reminiscing with medical school crony Andrew Hecht, Dr. Rast revealed his schooling. "I knew you'd get there Andy. Remember, we called you the Diamond up at P. & S." "¹¹⁴. In 1860, it sufficed Holmes to mention that Bernard Langdon was "attending Medical Lectures at the school connected with one of our principal colleges"¹¹⁵ as a first step towards professional goodness. By 1910, these criteria grew more stringent. Dr. Rast could not attend a nameless, random medical college and be assured of an identical reputation. Rather, he attended Columbia's College of Physicians and Surgeons, not only the second oldest medical school in America but also one affiliated with an première, prestigious university.

Dr. Rast's P. & S. training foiled that of Jane Grabo, a young medical student attending the "uptown Medical College"¹¹⁶. Jane's institution lacked comparable renown. Its descriptive 'uptown' was not capitalized; it served simply as a locational marker and hinted at the school's nondescript, probably proprietary, nature. Its formal name was never divulged. The educational deficiencies of her 'anonymous' school's educational program were duly noted.

¹¹³Ibid., pp.5-6.

¹¹⁴James Oppenheim, Doctor Rast, (New York, Sturgis & Walton Company, 1909), p.184.

¹¹⁵Holmes, op. cit., p.6.

¹¹⁶Oppenheim, op. cit., p.39.

Despite exposure to novel concepts including "the efficacy of ultra-violet rays in the treatment of cancer...the glory and mystery of running a ray of healing light through a diseased body"¹¹⁷, she received inadequate basic clinical training. Her failure to recognize her sister's developing pneumonia as it raged in front of her eyes for eight days¹¹⁸ emphasized this lapse.

The importance of attending a named university was also presented in The Healer (1911). Dr. Holden's youngest daughter Dorothy approached her estranged father seeking advice towards becoming a doctor. She presented her dilemma. "I-I want to be a doctor...Dr. Percy said I would have to go to college first...I mean a real university, not a woman's college-that's only another sort of boarding school...but I mean to be a doctor!...Yes! I've always wanted to be a doctor ever since I was a little thing"¹¹⁹. Dorothy knew how her father "became a great doctor, and had a wonderful hospital out in the woods for sick people...the sick people coming to you from all over to get well"¹²⁰ and sought his advice in selecting the proper educational pathway. Her finalized plan reaffirmed the need to attend prominent universities both at the collegiate and medical school stages.

By the 1920's, the emphasis placed on university-affiliated medical colleges was firmly established. Moreover, a hierarchy formed among the university programs themselves. Both Ephraim Nye and David Noble chose to attend

¹¹⁷Ibid., p.40.

¹¹⁸Ibid., p.52.

¹¹⁹Herrick, op. cit., pp. 427-429.

¹²⁰Ibid., p.430.

Harvard¹²¹. Dr. Noble's initial intentions, however, were to "bring in the precious money that would send him to the University of Vermont"¹²². Ultimately, he selected "Harvard instead of the University of Vermont"¹²³. He perceived Harvard as more opportune towards becoming "the greatest doctor in all New England"¹²⁴. Their premedical training received less emphasis. Dr. Nye's course was not referred to. Dr. Noble was "fortunate enough to get [his] degree at Harvard in three years"¹²⁵.

Only Martin Arrowsmith completed the entire Johns Hopkins recommendation. He attended the University of Winnemac as an "Arts and Sciences [student] preparing for medical school"¹²⁶ and introduced himself on his first day of medical school as "a medic freshman, Winnemac B.A."¹²⁷. He completed another four years at the University of Winnemac Medical School. Starting medical school, "he felt superior to his fellow medics, most of whom had but a high-school diploma, with perhaps one year in a ten-room Lutheran college among the cornfields"¹²⁸. Among his classmates, "[Angus] Duer was one of the few...in the academic course who had gone on with him to the Winnemac

¹²¹Joseph Crosby Lincoln, Doctor Nye of North Ostable, (New York, A.L. Burt Company, 1923) p.185 and Frances Parkinson Keyes, The Career of David Noble, (Cleveland, World Publishing Company, 1943), p.105.

¹²²Keyes, op. cit., p.37.

¹²³Ibid., p.93.

¹²⁴Ibid., p.97.

¹²⁵Ibid., p.110.

¹²⁶Sinclair Lewis, Arrowsmith, (New York, P.F. Collier and Son Corporation, 1925), p.8.

¹²⁷Ibid., p.12.

¹²⁸Ibid., p.11.

medical school"¹²⁹ and Ira Hinckley "was a graduate of Pottsburg Christian College and of the Sanctification Bible and Mission School"¹³⁰.

The second pivotal 1890's trend involved the widening spectrum of medical specialties and the burgeoning establishment of postgraduate medical education. Although the first specialty society, the American Ophthalmological Society was founded in 1864, with the subsequent founding of societies in neurology, gynecology and dermatology in 1875, 1876 and 1879 respectively¹³¹, it was not until the last decades of the nineteenth century that physicians began to identify themselves exclusively as specialists rather than generalists possessed of a particular skill¹³². Demographics limited specialism to urban areas which possessed both large patient pools and a concentration of physicians¹³³. During the 1870's, the general practitioner discriminated against the specialist¹³⁴. By the

¹²⁹ibid., p.16.

¹³⁰ibid., p.13.

¹³¹Stevens, op. cit., p.46.

¹³²Up to the 1880's, the majority of specialty-practicing physicians considered themselves 'partial specialists'. The partial specialist incorporated general physicians who in addition practiced a medical specialty. This popular course allowed for a focus of expertise without forgetting "the sympathetic connections between organs and the dependence of local diseases on general conditions". Lester S. King, "Medicine in the USA: Historical Vignettes XXI. Medical Practice: Specialization", *JAMA*, vol. 251 (1984), pp.1333-1338. By the mid 1880's, physicians shifted their reference for identification. The increase in scientific appreciation of specific organ pathology and pathophysiology promoted the growth of the 'exclusive specialist'. These physicians limited their practice to one specialty and capitalized on the opportunity to pursue research to enhance experimental data as well as diagnostic and curative skills. Stevens, op. cit., p.47.

¹³³King, Vignettes XXI, pp.1333-1338.

¹³⁴In 1869, the AMA, a predominantly generalist organization, adopted an initial platform on specialism. Although the organization agreed that specialists advanced the science of medicine, they voiced doubts concerning the specialists' benefit to medical practice. The AMA further promoted that specialists should be held responsible to the same ethical restrictions as generalists and decreed that "it shall not be proper for specialists publicly to advertise themselves as such or to assume any title not specially granted by a regularly chartered college". King, Vignettes XXI, pp.1333-1338.

1890's this attitude flipped by one hundred and eighty degrees. Specialists challenged the generalists' competency at diagnosing complex cases and performing procedures. Surgeons fought for the exclusive rights to the operating room¹³⁵. Ophthalmologists argued for sole jurisdiction over the eye¹³⁶. The generalist faltered as he felt his medical usefulness disappearing.

In addition to the generalist challenge, the specialists were also threatened by the 'pseudospecialist'¹³⁷. The pseudospecialist, having acquired dubious specialty training, eschewed the specialist's zeal for scientific inquiry. Nonetheless, attracted by the specialist's preferred socioeconomic standing, the pseudospecialist practiced "qualified quackery"¹³⁸, denigrating the entire specialist community¹³⁹.

¹³⁵Historically, American general practitioners performed surgical operations, often on the patient's kitchen table. Surgical procedures by necessity were minor; body cavities infrequently explored. Spurred by the 1880's incorporation of anaesthesia and antisepsis, surgeons obtained access to the abdomen, chest, nervous system. They developed technically demanding operations and cured previously morbid conditions including appendicitis and gastric ulceration. Surgeons argued that an operation's success was contingent on the operator's competency. They argued against the continued appropriateness for general practitioner to perform surgery on his patients. Only surgeons who devoted their entire practice towards perfecting their operating skills should obtain surgical privileges. Furthermore, they advocated special training programs to train aspiring surgeons and additional licensing criteria to facilitate identification of the qualified surgeon. Stevens, *op. cit.*, pp.80-81.

¹³⁶Ophthalmology, reacting to the challenge from both optometrists and general practitioners skilled in using the portable ophthalmoscope, recognized the need for legally distinguishing the qualified ophthalmologist from other practitioners. They established a standardized post-graduate curriculum and, in 1916, created the first specialty board of examiners to certify successful graduates. *Ibid.*, pp.110-113.

¹³⁷Initially appearing in the 1870's this group of physicians proliferated in the 1890's and 1900's. King, *Vignettes XXI*, pp.1333-1338; Stevens, *op. cit.*, p.49.

¹³⁸King, *Vignettes XXI*, pp.1333-1338.

¹³⁹Dr. Joseph Zeisler openly commented that "I have no hesitation in saying that we have too many specialists, but not enough good ones." Joseph Zeisler, "Specialties and Specialists", *Journal of the American Medical Association*, vol. 36 (1901), p. 2.

In his 1901 article, Joseph Zeisler outlined the ideal specialist's training itinerary. He characterized the specialist as "a man with an excellent preliminary education. This should even include a knowledge of the more important modern languages. He should have a broad, comprehensive medical training in college and hospital, particularly in pathology. In addition to this, he should have devoted, according to his line of work selected, from two to four years to his special studies, comprising clinical, literary and laboratory work. He should never lose the intimate contact with general medicine, and no matter how small the field of his special labors may be, he should always remain a physician"¹⁴⁰. The twentieth-century novels explored the distinguishing features of a specialist's training path.

Prior to Dr. Holden's first foray into the city, Herrick bolstered his educational background. He disclosed that Dr. Holden's "father was trader and doctor, rough surgeon too, with ambitions for his son. At eighteen the lad was sent away to get his education in his father's profession. Laboriously, under all the disadvantages of poverty and ignorance, he had slowly acquired his training in college, medical school, hospital,-even got abroad for some time. [He] was determined to be a great surgeon, like the famous men who taught [him]"¹⁴¹. Holden's credentials included all the stages the burgeoning surgical profession clamored for-undergraduate premedical training, medical school and postgraduate surgical training. Similarly, Dr. Noble completed postgraduate surgical training, by completing a fellowship under Dr. Ross, the renowned

¹⁴⁰ibid., pp.1-6.

¹⁴¹Herrick, Healer, p.50.

Boston surgeon. Angus Duer completed a two-year internship prior to accepting a position at the Rouncefield Surgical Clinic¹⁴².

Ephraim Nye pursued specialist training for neurology but never finished his course¹⁴³.

The prerequisite post-graduate specialist training is also emphasized in Doctor Bryson. In describing the students attending the Laflin College for the Eye and Ear in Chicago, "it must be considered that the courses at the Laflin institution are post-graduate: that every student is already a Doctor of Medicine"¹⁴⁴. Not only was the ophthalmologist required to complete a set postgraduate course, but admission to these programs was contingent on having already received the M.D..

By 1925, selecting the optimal educational criteria was no longer simple. Neither completing four years of undergraduate college nor pursuing extensive postgraduate training guaranteed evolution into a good physician. Fatty Pfaff, one of Dr. Arrowsmith's classmates, lacked formal undergraduate training. Moreover, academically he was "soft...superstitious...an imbecile"¹⁴⁵. Yet, he "was going to be an obstetrician...he sympathized with women in their gasping agony, sympathized honestly and almost tearfully"¹⁴⁶. Dr. Noble, however, was so engulfed with training to be a good physician that he never acted like one. Dr. Arrowsmith, despite his scientific acumen, was at best a passable physician. The

¹⁴²Lewis, Arrowsmith, p.270.

¹⁴³Lincoln, Dr. Nye, p.42.

¹⁴⁴Frank Hamilton Spearman, Doctor Bryson, (New York, Charles Scribner's Sons, 1904), p.3.

¹⁴⁵Lewis, Arrowsmith, p.128.

¹⁴⁶Ibid., p.115.

pivotal questions arose. Would scholastic achievement and success always correlate with the good physician? Did the emphasis on technical, specialized educational paths detract from the overall task of educating the good physician?

II. The American Medical College Curriculum

Intertwined with realizing the appropriate pathway towards professional accreditation was determining the essential knowledge complement required for professional autonomy. S.E.D. Shortt defined professionalization as the "process by which a heterogeneous collection of individuals is gradually recognized, by both themselves and other members of society, as constituting a relatively homogeneous and distinct occupational group"¹⁴⁷. For a starting point, such a group tended to coalesce around a specific body of knowledge¹⁴⁸.

Beginning in the 1840's¹⁴⁹, the regular profession rallied around its medical colleges' curricula as it strove to achieve autonomy. This stance provided the newly-organized profession two sources for strength. Firstly, the regular medical curriculum had been remarkably stable since its establishment on American soil. The formal American educational program was founded with the following tenets. Except for clinical anatomy demonstrations, all courses were structured around didactic lectures devoid of clinical or laboratory sessions.

¹⁴⁷S.E.D. Shortt, "Physicians, Science and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century", *Medical History*, vol. 27 (1983), pp.51-68.

¹⁴⁸Ibid., p.52.

¹⁴⁹When the AMA was founded in 1847, its members attempted to anchor the fledgling organization through its involvement with medical education. Its charter resolutions included a statement suggesting that medical terms increase from four to six months. This plan was uniformly ignored and embarked the AMA on a rocky fifty year relationship with the medical education establishment. Nonetheless, the AMA's initial efforts demonstrated the importance in recognizing and affiliating with a central knowledge foundation. Rothstein, op. cit., pp.283-284.

Students understood medical school to complement and not to replace the apprenticeship and acquired clinical training separately. The schools only had the responsibility to instruct in the sciences. These subjects- inorganic and organic chemistry, anatomy, physiology, physic and materia medica were considered masterable by only a few learned professors. Completing a medical course required attending two four month sessions in successive years. The curriculum was not graded; students repeated the same coursework each year, hoping to benefit from the repetition¹⁵⁰. By 1865, the only noticeable change was that most schools had extended the term to six months. Less than half had incorporated practical clinical rounds¹⁵¹. The principle of regular medical education was assumed to be a reliable tradition.

Secondly, it significantly differed from sectarian teachings.

Thomsonianism, a botanical sect, challenged the validity of mineral therapeutics and suggested the use of natural herbs in its stead. Thomsonianism also viewed formal institutions' admission standards as discriminatory against the common masses and supported home education via purchasable pamphlets¹⁵².

Eclecticism, another botanical sect, both chose to establish schools to legitimize their position and incorporated scientific training into their course. They, however, taught therapeutic conservatism and preached against regular medical heroics¹⁵³. Homeopathy, originating among wealthy immigrant German physicians, founded institutions which stressed the importance the

¹⁵⁰Ibid., pp. 88-89.

¹⁵¹Ibid., p.282.

¹⁵²Starr, op. cit., pp. 51-53.

¹⁵³Ibid., p.96.

doctor/patient relationship. Unlike the regular profession's drive to systematize disease, diagnosis and therapeusis, homeopaths stressed individualized diagnosis followed by customized infinitesimal therapy¹⁵⁴.

The medical profession, realizing its *raison-d'être* nestled within the *materia medica*, adopted the medical curriculum for professional authentication. However, the ensuing proliferation of scientific discoveries and clinical advances destroyed this comfortable, stable foundation. The period between 1859 and 1925 witnessed repeated physician reassessment of the medical curriculum as the focal source for professional identity. Specifically, debates raged about which topics were essential or superfluous to physician education. These challenges were reflected in the novels as they attempt to delineate which aspects of the American medical curriculum were integral to creating the good doctor.

Andrew Jackson Davis, in the opening lines of Tale of a Physician (1869), sums up the preferred requirements proving successful mastery of the 1860's medical curriculum. "The regularly graduated physician...he is furnished with a diploma of 'Doctor of Medicine'... He is supposed to be deeply versed in the laws of nature; to comprehend all the secret causes of human suffering; to be a perfect master in natural philosophy and to judge correctly of the physical condition, and even of the characters, of individuals, by examination and observation of their pulsations, tongues, countenances, gestures and other external peculiarities"¹⁵⁵. Davis accorded the physician with the task of developing observational skills, assimilating and correlating these findings with those already catalogued in the laws of nature-a fancy historian of the human condition.

¹⁵⁴Ibid., p.97.

¹⁵⁵Davis, Tale of a Physician, p.5.

These same aspirations were echoed in In War Time (1884) through Edward Morton's description of his appeal for medicine. "I suppose a doctor ought to be all of a man with the best of a woman. I think I should like to be a physician. The human nature he sees in its nakedness must be interesting, and a man who walks among the tragedies of life must have noble chances to help and guide and set folks right"¹⁵⁶. Edward fantasized that his ideal physician should combine the best Victorian philosophies of man-and womanhood: thrift, punctuality, capitalism and housewarming, supportive dignity¹⁵⁷. With specific regard to the physician, implicit was learning Davis's battery of tools, the correct accouterments to 'guide and set folks right'.

Dr. Kittredge's description elaborated on Davis's compendium. Dr. Kittredge's specimen room, his repository of medical memorabilia, "was a place such as anybody but a medical man would shiver to enter. There was the usual tall box with its bleached, rattling tenant; there were jars in rows where 'interesting cases' outlived the grief of widows and heirs in alcoholic immortality...there were shining instruments of evil aspect, and grim plates on the wall"¹⁵⁸. Preserved specimens marked the physician's reference collection.

¹⁵⁶Mitchell, In War Time, p.205.

¹⁵⁷Victorian American culture espoused the philosophies of 'duty' and 'virtue'. For women, Victorian culture was a culture of domesticity. Within these frameworks, idealized women were exalting displays of motherhood. Yielding all authority to her husband, her role was to softly and reassuringly manage the home and bolster her spouse's confidence such that he could best provide for the family. Being implicitly understood that without a female figurehead, the family would disintegrate, the woman's role had achieved a new level of dignity. The capitalist industrialism motivated the employable male society. All activities, from business to religious devotion to controlling one's undesirable habits were embraced with a competitive spirit. Their most important commodity was time. For this future-oriented culture, misusing present time would only translate into future deficits. Strongest consideration was given to the highest standards of excellence and efficiency. Daniel Walker Howe, "Victorian Culture in America", in Victorian America, ed. by Daniel Walker Howe (Philadelphia, University of Pennsylvania, 1976), pp. 18-26.

¹⁵⁸Holmes Elsie Venner, p.215.

Clinically, "the doctor knew a good many things besides how to drop tinctures and shake out powders...He knew what a nervous woman is and how to manage her. He could tell at a glance when she is in that condition of unstable equilibrium in which a rough word is like a blow to her, and the touch of unmagnetized fingers reverses all her nervous currents...The Doctor knew the difference between what men say and what they mean as well as most people..."¹⁵⁹. Dr. Kittredge, in addition to having studied the laws of nature and disease, developed insight into the human condition.

Nineteenth-century reformers advocated that young medical students not view their studies as ending at graduation. Educators scoffed at students who limited their education to published textbooks. Students were expected to seize the opportunity to discover new knowledge¹⁶⁰. Mitchell advocated this ideal. Following Captain Grey's death from bacterial empyema, Dr. Lagrange challenged Dr. Wendell to pursue novel investigation. "What a rapid case of pyaemia! I wish one understood it better, or that somebody could take it up and work at it. We have plenty of material. Why could not you [Wendell] try your hand?"¹⁶¹.

Manual dexterity and surgical competence were not essential to the physician. Davis separated the roles of physician and surgeon and had not required his physician to be an interventionalist. Having been stabbed, Captain Nelson ordered "Now send for the surgeon and physician, whose office is ten doors above, on this side of the street. Be quick! I am bleeding!"¹⁶². Wound

¹⁵⁹ibid., p.98-99.

¹⁶⁰John S. Haller, Jr., "The Artful Science': Medicine's Self-Image in the 1890's", *Clio Medica*, 19 (1984), pp.231-250.

¹⁶¹Mitchell, In War Time, p.34.

¹⁶²Davis, Tale of a Physician, p.142.

repair required the expertise of a surgeon, distinguishable from the average physician.

The 1860's status quo could not be maintained. Already by the early 1870's, that quintessential satisfaction with the physician's educational requirements, reflected in the earliest novels, began to unravel. Throughout the 1860's, Harvard Medical College, through its affiliation with the proprietary Tremont Medical School, began to experiment with curricular innovations which reflected the growing compendium of scientific and medical information. These additions, in both experimental scientific progress and specialty courses, crowded the standard six month schedule. The Harvard leaders, arguing that lectures only promoted inefficient passive learning, sought to increase the amount of practical instruction. The Tremont catalog touted "devoting additional time to *clinical instruction* ...Surgical operations at the hospital; exercises with the microscope, abundant morbid specimens in the important course of pathological anatomy..."¹⁶³.

In 1871, Charles William Eliot, President of Harvard University, officially integrated these elective course offerings into the medical school curriculum and stimulated the first definite reform to American medical education¹⁶⁴. Harvard replaced its four-month winter term and spring/summer electives with a mandatory nine-month session with clinical and practical sessions integrated into lecture time. The program was extended to three graded years, beginning

¹⁶³Huddle, *op. cit.*, p.350.

¹⁶⁴Eliot's principal motivation was his frustration that medical students were held to lower standards than other Harvard students. Only a few years following the reforms did he proudly claim that medics could claim equal pride in being Harvard men. *Ibid.*, pp.340-365.

with fundamental studies and culminating in clinical instruction. Some courses required final examinations¹⁶⁵.

Over the next twenty years, numerous schools adopted portions of the Harvard reforms to their curricula. Schools lengthened their curricula to six months (short of Harvard's nine) and instituted a graded program. Many programs added a third year to integrate the growing number of elective offerings. Many of the innovations centered around the establishment of clinical courses¹⁶⁶. Cable, in Dr. Sevier, described these trends.

Part of Dr. Sevier's clinical responsibilities included "his ward in the great Charity Hospital, and the school of medicine, where he filled the chair set apart to the holy ailments of maternity"¹⁶⁷. Unlike Bernard Langdon's schooling, which necessitated his "[re]appearance a week or two later at the Lectures"¹⁶⁸, Dr. Sevier's course was not restricted to a classroom and podium. Adopting the Parisian style of ward rounds¹⁶⁹, "he tarried a moment...just where you enter the

¹⁶⁵Eliot did not possess his faculty's unanimous support for his reform package. While young faculty touted Eliot's attempts to found the German research ethic at Harvard, senior faculty including Henry James Bigelow and Oliver Wendell Holmes, Sr., opposed the innovations. Their principal concerns focussed on experimental sciences supplanting therapeutic competence as medical education's prime directive. They worried about a reprioritization of medicine away from healing. Ibid., pp.340-365.

¹⁶⁶Lester S. King, "Medicine in the USA: Historical Vignettes XIX. Medical Education: The Decade of Massive Change", *JAMA*, vol. 251 (1984), pp.219-224.

¹⁶⁷George Washington Cable, Dr. Sevier, ed. by Arlin Turner, (New York, Garrett Press, 1970), p.6.

¹⁶⁸Holmes, Elsie Venner, p.480.

¹⁶⁹Paris's leading attraction for American medical students was their organized clinical curriculum. Students would first attend lectures on specific disease processes and then follow clinicians onto the wards for physical diagnosis demonstrations. The Parisian hospital wards were segregated by disease, allowing for easier identification of specific illness patterns. Moreover, students had open access to all patients' bodies, living or dead. Students had the unique opportunity both to appreciate disease natural history and to correlate observed symptomatology with didactic teachings. Warner, Therapeutic Perspective, pp.186-187.

ward and before you come to the beds. He had fallen into discourse with some of the more inquiring minds among the train of students that accompanied him...the question was public sanitation"¹⁷⁰. The ensuing recount of the attending teaching rounds not only demonstrated appropriate medical school subject material but also the nuances of the teacher/student relationship.

"He [Dr. Sevier] was telling a tall Arkansan, with high-combed hair, self-conscious gloves, and very broad, clean-shaven lower jaw, how the peculiar formation of the Delta lands, by which they drain away from the larger watercourses, instead of into them, had made the swamp there in the rear of the town, for more than a century, 'the common dumping-ground and cesspool of the city, sir!.' Some of the students nodded convincingly to the speaker; some looked askance at the Arkansan, who put one forearm meditatively under his coattail; some looked through the window over to the regions alluded to, and some only changed their pose and looked around for a mirror.

The Doctor spoke on. Several of his hearers were really interested in the then unusual subject, and listened intelligently, as he pointed across the low plain...'every drop of its waters, and every inch of its mire saturated with the poisonous drainage of the town!' 'I happen', interjected a young city student; but the others bent their ear to the Doctor, who continued:-'Why, sir, were these regions compactly built on, like similar areas in cities confined to narrow sites, the mortality, with the climate we have, would be frightful.' 'I happen to know', essayed the city student; but the Arkansan had made an interrogatory answer to the Doctor, that led him to add:-...'I hap-', said the city student. 'And yet', exclaimed the Doctor, 'Malaria is king!' He paused for an instant for his hearers to take in the figure. 'Doctor, I happen to'- Some one's fist from behind caused the speaker to turn angrily, and the Doctor resumed:-.... 'Why, Doctor,' said the city student, ruffling with pride of his town, 'there are plenty of cities as bad as this. I happen to know for instance'- Dr. Sevier turned away in quiet contempt. 'It will not improve our town to dirty others, or to clean them either'.

He moved down the ward, while two or three members among the moving train, who never happened to know anything, nudged each other joyfully. The group stretched out and came along, the Doctor first and the young men after, some of one sort, some of another,...-following slowly, pausing, questioning, discoursing, advancing, moving from each clean, slender bed to the next, on this side and on that, down and up the long sanded aisles, among the poor sick women...Presently, the tones of the Doctor's voice could be heard, soft, clear, and without the trumpet quality that it had beyond the sick-room"¹⁷¹.

¹⁷⁰Cable, Dr. Sevier, p.100.

¹⁷¹Ibid., pp.100-102.

The inclusion of teaching rounds into the medical curriculum marked a focal shift in medical educator responsibility. Previously, the medical school largely restricted its offerings to didactic seminars; students were expected to obtain their practical clinical education elsewhere. Frequently, this propelled students towards inferior apprenticeships and produced dubiously qualified physicians despite a formal medical training. By adding clinical diagnosis and bedside management to the formal medical curriculum, educators could regulate clinical training. By bestowing established, renowned physicians with the responsibility of bedside seminars, medical schools guaranteed the quality of their graduates clinical training. The responsibility for clinical training had effectively shifted from the variably qualified preceptor to the formal medical college.

In 1893, the opening of the Johns Hopkins Medical School established new standards for the medical curriculum. Not only did it offer a four-year graded curriculum with strong grounding in both basic and clinical sciences but it required an accredited A.B. degree prior to matriculation¹⁷². Johns Hopkins's standards exceeded any contemporaries'-worldwide. The Johns Hopkins success prompted the American Association of Medical Colleges (AAMC), in 1895, to promote basic recommendations for both the premedical¹⁷³ and medical curricula¹⁷⁴.

¹⁷²Stevens, op. cit., p.57.

¹⁷³The AAMC advocated a minimum of two years of high school but ultimately hoped for the same stringent requirements needed for admission to a regular liberal arts college. King, Vignettes XIX, pp.219-224. By 1909, university level premedical training became standard. Educators' superior regard for premedical scientific training promulgated that students pursuing an undergraduate humanities course neglected medicine's scientific calling and lacked sufficient mettle to join the 1910's medical profession. Lester S. King, "Medicine in the USA: Historical Vignettes XX. The Flexner Report of 1910", *JAMA*, vol. 251 (1984), pp. 1079-1086.

¹⁷⁴The AAMC outlined specific plans for a four-year medical curriculum, drawing heavily on the Johns Hopkins experience. The first year should be devoted to general and physiologic chemistry,

This 1895 syllabus was, in effect, a blueprint for medical education's future. The Harvard reforms stimulated dissenting academicians. One generation later, university academics encountered the Johns Hopkins program with resounding acceptance. In 1905, the Confederation of State Medical Examining and Licensing Boards adopted the AAMC's program¹⁷⁵. In his 1910 report, Abraham Flexner observed that "there is no denying that especially in the last fifteen years, substantial progress has been made"¹⁷⁶ and reiterated the AAMC's suggestions. Following the Flexner Report's publication, these idealized goals were adopted as the accepted standard. Flexner's report verbalized the prevailing sentiment within the medical community-that a good doctor could only develop subsequent to acquiring a scientifically oriented but clinically integrated curriculum¹⁷⁷.

Sinclair Lewis offered Martin Arrowsmith's education as an optimized example of the new curriculum. Beginning during boyhood, Dr. Arrowsmith's training evolved through all the stages recommended in both the AAMC guidelines and the Flexner Report.

biology (where the student would acquire a "broadened idea of the phenomena of life in animals and plants), histology, embryology, gross anatomy, physiology and dabbles of materia medica. The second year would continue work in physiology and gross anatomy while adding pathology and bacteriology. It would also feature clinically oriented physical diagnosis, hygiene and an elective. Laboratory work or seminars would be integrated in all subjects. Third and fourth years would be dedicated to clinical sciences, replete with hospital demonstrations. King, Vignettes XIX, pp.219-224.

¹⁷⁵Hudson, op. cit., pp.545-561.

¹⁷⁶Ibid., p.560.

¹⁷⁷Absent from 1880's and 1890's ideologies, the application of scientific thought gained prominence in the first decade of the twentieth century. The good student (and subsequently the good doctor) was expected to apply the scientific method towards problem solving. This "training of the mind" involved observing carefully, reasoning carefully, studying effectively and judging wisely. This was considered achievable exclusively in a university operated medical school highly steeped in scientific principles. King, Vignettes XX, pp.1079-1086.

Dr. Vickerson, the local practitioner in Elk Mills, a small midwestern town, advised his young protégé Martin Arrowsmith to "set a high goal. Don't let things slide. Get training. Go to college before medical school. Study. Chemistry. Latin. Knowledge!"¹⁷⁸. Spurred by Dr. Vickerson's advice, Martin Arrowsmith's medical education recapitulated the pristine Johns Hopkins model. As a junior in college, "the purpose of life was chemistry and physics and the prospect of biology next year"¹⁷⁹, a worthy premedical course. His first year of medical school was punctuated by physiology and gross anatomy. "For all his pride, Martin was nervous. He thought of operating, of making a murderous wrong incision; and with a more immediate, macabre fear, he thought of the dissecting-room and the stony, steely Anatomy Building"¹⁸⁰. The original anxiety faded as "in the dissecting-room were many pleasantries"¹⁸¹. Of the curriculum, "Martin was restless...In melancholy worry about his own unreasonableness, he found that he was developing the same contempt for Robertshaw's [physiology] rules of thumb-and for most of anatomy"¹⁸². Second year continued his basic science training. Coursework included bacteriology, pathology, hygiene, surgical anatomy, "and enough other subjects to swamp a genius"¹⁸³. "He was particularly tedious in materia medica"¹⁸⁴. Bacteriology class

¹⁷⁸Lewis, Arrowsmith, p.4.

¹⁷⁹Ibid., p.8.

¹⁸⁰Ibid., p.11.

¹⁸¹Ibid., p.21.

¹⁸²Ibid., pp.20-21.

¹⁸³Ibid., p.40.

¹⁸⁴Ibid., p.41.

was supplemented by laboratory exercises, including extensive microscope use¹⁸⁵.

"His junior year was a whirlwind. To attend lectures on physical diagnosis, surgery, neurology, obstetrics, and gynecology in the morning, with hospital demonstrations in the afternoon"¹⁸⁶. Clinical material with concurrent daily ward rounds comprised his entire last two years. "Neurology, O.B., internal medicine, physical diagnosis; always a few pages more than he could drudge through before he fell asleep at his rickety study table. Memorizing of gynecology, of ophthalmology, till his mind was burnt raw. Droning afternoons of hospital demonstrations, among stumbling students barked at by tired clinical professors. The competitive exactions of surgery on dogs"¹⁸⁷. Fourth year continued along the same pace: "neurology and pediatrics, practical work in obstetrics, taking of case-histories in the hospitals, attendance on operations, dressing wounds"¹⁸⁸. Martin followed his medical school experience with a two-year internship at the Zenith General Hospital¹⁸⁹.

Lewis emphasized this curriculum's completeness. Yet, he vacillated on its role in generating good doctors. Its graduates covered the entire spectrum of doctoring. Martin Arrowsmith developed into an exemplary clinical scientist but a poor physician. Angus Duer acquired sharp surgical skills coupled to an

¹⁸⁵Ibid., p.52.

¹⁸⁶Ibid., p.52.

¹⁸⁷Ibid., p.83.

¹⁸⁸Ibid., p.114.

¹⁸⁹By 1914, it was estimated that 75 to 80 percent of all medical graduates were pursuing an internship. Five medical colleges required the internship for the M.D. degree and the Pennsylvania State Board required it for licensing. By 1925, twelve states followed Pennsylvania's example and by 1932, the total was up to seventeen. Stevens, op. cit., p.118.

uncompassionate personality. Irving Watters opting for suburban family practice, concentrated equal effort on golf. Fatty Pfaff nearly flunked his scientific course yet developed admirable obstetrical skills. Ira Hinckley mastered his curriculum and devoted his life to compassionate medicine in the third world. The post-Flexnerian medical curriculum did provide the requisite scientific and clinical background the 1910's and 1920's society demanded of its good physicians. Yet, acquiring this knowledge did not guarantee a good doctor. Good doctoring required something in addition to a solid educational background.

The twentieth century also ushered in increased emphasis on medical specialism. Patients were showing an increased demand for specialists, often bypassing the generalist consultation. Jealous, generalists freely attacked the specialist's medical shortcomings. They frequently demonstrated instances of bad medicine stemming from the specialist's inadequate training coupled to ignorance of general issues lying outside their immediate specialty¹⁹⁰. These accusations provoked the debate of defining adequate specialist training. From the outset, specialists recognized their needs as different from the generalist. Whereas practice maximized the generalist's potential, hospital training was deemed most appropriate for the specialist ¹⁹¹. While the generalist could open an office immediately upon receipt of the M.D., the specialist required additional postgraduate training in a large clinic dedicated exclusively to the specialty and staffed with superlative teachers. "The man who, without such schooling, dashes

¹⁹⁰King, Vignettes XXI, pp.1333-1338.

¹⁹¹In 1901, it was commonly accepted that following five to ten years of general practice, a physician would be prepared for specialist practice. The rise of postgraduate hospital training favored a different option-the two-year rotating internship. Hospital work was considered of a higher scientific order, more apt to foster the requisite discipline to pursue one subject in depth. General practice established a physician in a time constraining routine that would preclude independent research. Zeisler, op. cit., pp.1-6.

into a specialty is likely to use his private patients as a material for his studies...it is this kind of specialists who, by their blunders in their first years of practice, bring discredit on the whole institution"¹⁹².

Dr. Bryson's educational program at the Laflin College for the Eye and Ear provided an example of organized, quality specialty training. Despite that "every student is already a doctor of medicine"¹⁹³, they have no clinical autonomy-"the student must follow the clinic; he cannot lead it"¹⁹⁴. The courses centered around the operating table. Students mingled "with the white-gowned nurses and surgeons who stood about the operating table"¹⁹⁵. Attentive operative technique observation was essential. During an operation, Dr. Bryson frequently paused and asked: "Now gentlemen, tell me what nerve we have here. Don't all speak at once"¹⁹⁶. Following the demonstrations, "Dr. Bryson...rounded up informally and amiably his class talk, throwing into it nuggets of advice smoothed with pleasantries and polished with conciseness. The men filed from the benches, some leaving the room, more crowding forward to ask questions"¹⁹⁷. Dr. Bryson, however, adopted a unique and radical position regarding students performing surgery. "No student of the institution will be permitted to touch the eye of a clinic patient. Operations upon the eye, however slight, must be performed by the surgeons and the assistant surgeons of the

¹⁹²Ibid., p.3.

¹⁹³Spearman, Doctor Bryson, p.3.

¹⁹⁴Ibid., p.4.

¹⁹⁵Ibid., p.32.

¹⁹⁶Ibid., p.64.

¹⁹⁷Ibid., p.36.

staff...Let the poor be assured that there will be no experimenting in their distress"¹⁹⁸. Dr. Bryson hoped to elevate the specialist's authority by limiting incompetent practices.

The specialist, even after his training, needed to devote considerable time for contemporary literature review. Dr. Bryson, confronted with Ruth's glaucoma, combed the medical literature to reinforce his diagnosis and search for new data on its elusive etiology. "He walked to his office and went to the library. He read till six o'clock...going instead straight upstairs to the den...His capacity for research was enormous, for at half-past eleven,...he was reading...and Bryson was reading. It was one o'clock...the student lamp was burning. Bryson's books lay in a heap on the floor and he sat with his legs crossed before the dying fire, his head supported wearily on his hand. Six hours of reading...not new stuff; he had gone over it many times before. Little, so little new,...so little absolute, so much relative...grim, mysterious, deadly disease...the spectre of glaucoma"¹⁹⁹. Dr. Bryson himself was an adroit specialist. Under his tutelage, students could develop the essential tools and emulate their mentor.

III.The European Influence

The American medical profession, since its inception, had survived in a love/hate relationship with its European cousins. American physicians recognized their indebtedness to European medicine. Medicine in the United States grew directly out of British medical traditions; the earliest American physicians were first British immigrants and then Americans studying abroad in

¹⁹⁸Ibid., p.3.

¹⁹⁹Ibid., pp.55-56.

London and Edinburgh²⁰⁰. Americans constantly sought supplemental training in Europe²⁰¹. Yet, the organization and authority of the European medical juggernaut instilled in American physicians feelings of inferiority and jealousy²⁰². Americans endlessly looked towards the day when they could claim equal footing with their European colleagues. The evolution of the American physician's conflicting relationship with its European influence was portrayed through the fictional physicians' practices, goals and aspirations.

The 1860's European Mecca of clinical medicine resided in Paris, France. Founded under the spirit of the French Revolution, by the 1830's the school had established novel standards for clinical experimentation and bedside observation. It had also opened and extended its hospital system²⁰³. Its chief mentor was Pierre Louis, the renowned clinician. Dr. Louis appreciated following a disease's natural history, recording evidence of disease progression through repeated physical examination and objective data collection²⁰⁴. His

²⁰⁰King, Vignettes I, pp.217-220.

²⁰¹Between 1749 and 1800, 117 Americans received their entire M.D. training from the University of Edinburgh alone while many others studied there for shorter periods of time. Each decade, the amount of voyaging students increased. In the period between 1870 and 1914, no less than fifteen thousand students completed some medical or postgraduate course in the German system. Bonner, German Universities, pp.4 & 23.

²⁰²The British constantly taunted about the newness of American culture. Particularly irksome to physicians were accusations resounding "what does the world yet owe to American physicians or surgeons?" Witnessing the great European accomplishments only further irritated the American that his time had yet to come. Ibid., p.8.

²⁰³Albert S. Lyons and R. Joseph Petrucelli, Medicine-An Illustrated History, (New York, Abradale Press, Harry N. Abrams, Inc., 1978), p.511.

²⁰⁴In Louis's days, objective data were limited to those obtainable by stethoscope and naked palpation and percussion. However, his philosophy espousing the recording of daily vital signs was carried into temperature, blood pressure, and blood and urine parameters as soon as the necessary instruments to record these values became available. Warner, Therapeutic Perspective, pp.154-157.

techniques trained students in "the exact study of disease", preaching of "the danger of admitting anything which is not deduced from well-observed facts"²⁰⁵. By withholding standard heroic therapeutics, Louis recorded the complete natural histories for many illnesses, novel data in many instances²⁰⁶.

Dr. DuBois showed his admiration for the general European medical establishment and for Paris in particular. Not only did he obtain his M.D. from Paris²⁰⁷ but he also returned to the Continent years later for additional interests. His itinerary read as a catalogue for the best institutions Europe had to offer: "London, Berlin, Leipzig, Paris, Florence, Rome, Stockholm, Vienna..."²⁰⁸. Dr. DuBois explained the fruits of his travels: his newly acquired knowledge on mesmerism. "I have during my travels on the Continent, seen most astounding facts; I find that animal magnetism is reviving, or rather steadily growing, as a recognized curative and anaesthetic agent in Europe...In France it is used very extensively to produce insensibility under surgical operations. Germany makes more of a general use of it in the cure of nervous and mental diseases, from hysteria to lunacy, and Saxony recognizes it by prescribed regulations for its operations. Italian scientific societies have latterly taken it up for investigation, and although in conservative old England the faculty still holds back, high medical and scientific individual authorities have endorsed it as at all events a valuable anaesthetic"²⁰⁹. Dr. DuBois, in summarizing the uses of mesmerism,

²⁰⁵ibid., p.25.

²⁰⁶ibid., pp. 24-25.

²⁰⁷Davis, Tale of a Physician, p.37.

²⁰⁸ibid., p.146.

²⁰⁹ibid., p.148.

captured in microcosm each European country's diagnostic strengths and prevailing philosophies.

Dr. Sloper's conduct in Washington Square (1884) reflected the prevalence of Parisian styled medicine. His diagnostic and therapeutic strategies mirrored Dr. Louis's doctrines. Dr. Louis, to effect his "closer study of nature and of each fact in medicine...instead of trying the effects of emetics and extensive blisters...wait[ed] till death is just at hand and then, order a blister of 3 inches square to the legs...[after making his diagnosis] he finishes there-is very weak at therapeut, and is perfectly satisfied cum a correct diagnosis"²¹⁰. Dr. Sloper handled his daughter's courtship in a similar manner. From his first meeting, Dr. Sloper took Morris Townsend for "not a commonplace young man...and he took the liberty of not believing everything that his talkative guest narrated"²¹¹. Dr. Sloper immediately decided that the young man was "not what I call a gentleman...He is extremely insinuating; but its a vulgar nature...He is a plausible coxcomb"²¹² and "looking for it [a situation] here-over there in the front parlor. The position of husband of a weak-minded woman with a large fortune would suit him to perfection"²¹³.

After Catherine's engagement, he challenged his daughter. "You are quite right. I don't like him...I don't know him intimately. But I know him enough; I have my impression of him...You know a part of him-what he has chosen to

²¹⁰James Jackson Jr., quoted in Warner, Therapeutic Perspective, p.25.

²¹¹Henry James, Washington Square, (New York, New American Library of World Literature, Inc., 1964), p.38.

²¹²Ibid., pp. 40-41.

²¹³Ibid., p.46.

show you. But you don't know the rest"²¹⁴. Dr. Sloper professed his diagnosis; his daughter had missed key insights into her fiancé's character. His therapeutic course was not to intervene but simply to observe its natural history unfold. The thrill was in determining whether the preliminary assessment had been correct, irrespective of the patient's worsening condition. Ultimately, the youth shattered Catherine's spirit by canceling the engagement. Nonetheless, Dr. Sloper behaved unusually elated at his daughter's broken heart; his happiness stemmed from "I had foretold it! It's a great pleasure to be in the right!"²¹⁵. Dr. Sloper, like Dr. DuBois, had perfectly integrated the Parisian system into his own.

Yet, Dr. Sloper's adoption of Parisian ideology received a totally opposite response than did Dr. DuBois's. Lawyer Ruggleston was captivated by Dr. DuBois's mesmerism, symbolic of the European tradition²¹⁶. Mrs. Penniman, however, chastised her brother, Dr. Sloper; "your pleasures make one shudder"²¹⁷. Dr. DuBois considered European education compatible with the good American physician. Mrs. Penniman felt otherwise. This dichotomy demonstrated the American conflict surrounding the European medical traditions. The American physician enjoyed pursuing the newest European innovations. Nonetheless, he often questioned whether these imported strategies were compatible with the evolving American professional identity.

In 1870, the prominence of German medical programs began to overshadow the French institutions. As early as 1840, the German Universities

²¹⁴Ibid., pp.58-59.

²¹⁵Ibid., p.152.

²¹⁶Davis, Tale of a Physician, p.149.

²¹⁷James, Washington Square, p.152.

discarded science as an ethereal, romantic concept and replaced it with a philosophy stressing the unity of knowledge. Founding the principle that all scientific facts must be interrelated, they established centers for experimental research hoping to uncover these missing links. By 1860, foreign students in Europe discovered the scientific revolution across the Rhine and slowly left Paris for points eastward. By 1870, Paris had been all but forgotten. Americans in particular were lured by the excitement generated by the scientific laboratory, poised on the frontier of medicine²¹⁸. Americans wishing to acquire scientific skills pursued their education at the smaller colleges such as Leipzig, Freiburg, Munich and Heidelberg²¹⁹. The majority of Americans, however, sought clinical training, predominantly specialty training, and crowded the classes at Vienna and Berlin. Ten thousand Americans, between 1870 and 1914 followed this path²²⁰. These two institutions featured a quality of postgraduate training unavailable in the United States²²¹, with courses taught by their contemporary world authorities²²². Viennese professors taught courses in English specifically aimed at the American student. An entire German establishment grew around the American market. Americans looked towards Germany for clinical guidance and returned home to establish themselves either as clinical specialists or as basic scientists.

²¹⁸Bonner, op. cit., pp.15-17.

²¹⁹Ibid., pp.34-38.

²²⁰Ibid., p.69.

²²¹Nonetheless, Americans did claim supremacy in several fields, including Dentistry and Gynecology. Ibid., p.10.

²²²Examples of German professors included: Politzer, Gruber and Schrötter in Otolaryngology, Kaposi in Dermatology, von Pirquet in Pediatrics, Rokitsansky in Internal Medicine and Billroth in Surgery. Ibid., pp.75-76.

The first decades of the twentieth-century portrayed a shifting perspective within the conflicted American/European medical relationship. Americans were no longer concerned whether haughty European philosophy was an appropriate contribution to American medicine. The American medical profession began to develop its own identity and competed in its own right with the European giants. American physicians regarded Europe's medical community as a technological barometer, measuring the best standard of care. This new generation of Americans diffused their 'European superiority' tensions through the development of American scientific discoveries and medical technologies that would not only equal but surpass the best European efforts.

The Laflin College's trustees, looking to bolster the institution's reputation, enlisted Dr. Henry Elwood Bryson as surgeon-in-chief. The gauntlet challenged to "work up a clinic here that will beat Vienna...It can be made to beat Vienna...to beat Vienna, they [the trustees] well knew, would be to beat the world"²²³. Vienna, with Graefe's, Hirschberg's, Arlt's and Jaeger's clinics in ophthalmology, was ubiquitously considered the standard of excellence, having trained the majority of the prominent contemporary American ophthalmologists²²⁴. The Americans were gunning to surpass this plateau with their own work.

Max Gottlieb portrayed the German scientific émigré, an innovator hoping to advance scientific discoveries through capturing the American competitive spirit. Dr. Gottlieb, however, was marked by his Germanness, and this singled him out as different. His German education and training were duly noted-"I took an M.D. label-in Heidelberg that was...back in 1875...I was a follower of

²²³Spearman, Doctor Bryson, p.3.

²²⁴Bonner, op. cit., pp.90-91.

Helmholtz"²²⁵. His speech was tagged "with a hint of German accent...his words...colored with a warm unfamiliar tint"²²⁶. Dr. Gottlieb further estranged himself by invoking the German perspective on American experimental inferiority to his medical school class. "Technique, gentlemen, is the beginning of all science. It iss also the least known thing in science...and the most important part about experimentation is not doing the experiment but making notes, ve-ry accurate quantitative notes-in ink. I am told that a great many clever people feel that they can keep their notes in their heads. I have often observed with pleasure that such persons do not have heads in which to keep their notes. This iss very good, because thus the world never sees their results and science is not encumbered with them"²²⁷. Dr. Gottlieb's misdirected critique of his American colleagues only embroiled the conflicting factions in intensified competitive spirit.

Enticed by the European presence, American physicians worked to achieve professional parity. Dr. Bryson was both incredulous and excited that a prescription he wrote was "the very same pills [Miss Montague's] Paris doctor did. They are made in Paris...He [Dr. Bryson] thinks so highly of the Paris doctors"²²⁸. Dr. Noble commented that the clinical conference he attended in London "meets in various capitals from year to year. Last summer it was in Paris, and next year, I believe, to be in New York"²²⁹. The 'capital' could only refer to

²²⁵Lewis, Arrowsmith, p.38.

²²⁶Ibid., p.12.

²²⁷Ibid., p.35.

²²⁸Spearman, Doctor Bryson, pp.194-195.

²²⁹Keyes, David Noble, pp.109-110.

medical capitals; New York City was not a political capital. The United States had produced a medical center named in the same breath as London and Paris.

The most convincing victories were expressed by Europeans themselves. Dr. Arrowsmith, returning from St. Hubert was greeted press releases suggesting that "America, which was always rescuing the world from something or other, had gone and done it again"²³⁰. American medical accomplishments acquired world-wide prominence. Dr. Bryson was similarly greeted. Presenting a consult to a Parisian mentor, he received unexpected advice: "'My dear doctor, why have you brought her over to me? I have just sent a woman, with as extraordinary a case of hysterical amblyopia, over to you'. But he gave me no light"²³¹. The challenge had come full circle. American medicine surpassed the European expertise. European study was no longer considered a significant factor towards becoming a good American physician²³². Moreover, European physicians began looking across the Atlantic for consultative advice.

²³⁰Lewis, Arrowsmith, p.402.

²³¹Spearman, Doctor Bryson, p.299.

²³²By 1910, the educational value of a short clinical course in Vienna or Berlin was questionable. Spurred by the Flexner Report, the improving quality of American undergraduate and postgraduate medical education obviated the need to travel abroad to polish one's medical education. The American movement to Vienna peaked at the turn of the century, slowly fell and crashed after the assassination at Sarajevo. Some Americans chose to remain at home for their education. Others selected to attend Viennese classes more to experience the foreign culture and beer than their medicine. By 1914, it was recognized that more physicians were going abroad for the identical training they would have received in the United States. Bonner, op. cit., pp. 75, 103-106.

CHAPTER 2: THE DOCTOR/PATIENT RELATIONSHIP

In 1869, Andrew Jackson Davis presented the physician's pivotal function: his responsibility to patient care. "It is manifestly the first duty of the physician to study his patient's malady, and administer such remedial agents as will deaden and destroy suffering, and sustain the vital principle, without diminishing the constitutional systolic and diastolic movements of the heart"²³³. Davis, however, restricted his opinion to the technical, procedural focus of medicine. Oliver Wendell Holmes, Sr., captured the physician's second, hidden responsibility to establish the therapeutic alliance-the doctor/patient relationship. "The way a patient snatches his first look at his doctor's face, to see whether he is doomed, whether he is reprieved, whether he is unconditionally pardoned, has really something terrible about it"²³⁴. Holmes alluded to the unique bond that formed between a sick patient and his healer.

In her doctoral thesis, Mary Ann Cook studied the evolution of the doctor/patient relationship as it paralleled the growth in medical technology from the Civil War to the 1970's. She noted that consistently through history patients romanticized the doctor/patient interaction. "It is of a dedicated family physician making housecalls in the middle of the night, often traveling long distances into the country; a doctor who is intimately acquainted with both the medical and social histories of his patients"²³⁵. She contrasted this image to the nineteen-eighties reality where patients are often passed among a passel of

²³³Davis, Tale of a Physician, p.6.

²³⁴Holmes, Elsie Venner, p.424.

²³⁵Cook, Patient Satisfaction With Patient-Physician Interaction, p.2.

specialists and subjected to strings of diagnostic testing. Patients, however, did not seek medical attention as a means of repairing damaged biology. Illness disrupted a patient's daily living and threatened his/her sense of connectedness to society. Establishing connectedness with the physician served to dismantle some of this isolational feeling²³⁶.

Despite medicine's continued technological advances, patients never exclusively evaluated their physician based upon his/her depth of medical knowledge or technical competence. Rather, patients consistently remained attuned to the emotional, human aspects of medical care and preferred a pleasant personality coupled with unhurried devotion of time, patience and understanding²³⁷. The willingness to listen and to demonstrate unhurried concern remained as paramount qualifications. The successful doctor/patient relationship demanded physician involvement beyond taking a history/physical and dispensing therapeutics.

The good doctor could be measured by how consistently he initiated and executed a satisfactory doctor/patient relationship. In this section, I have highlighted several components of the physician's interactive style that particularly influenced the timbre of the doctor/patient relationship. The novels depicted a group of physicians representing a spectrum of interactive styles as well as offered insight into their relative successes and merits as good physicians. Each style could be seen as a composite of the same essential elements integral to the doctor/patient relationship. I have classified these components into two distinct categories. The first group, exemplified by observational techniques,

²³⁶Anthony L. Suchman and Dale A. Matthews, "What Makes the Patient-Doctor Relationship Therapeutic? Exploring the Connexional Dimensions of Medical Care", *Annals of Internal Medicine*, vol. 108 (1988), pp.125-130.

²³⁷Cook, *op. cit.*.

represented those techniques that retained constant level of importance throughout the study period. The second included characteristics whose relative value for a successful doctor/patient interaction constantly fluctuated. I have represented this group through comparing the relative importance of four variable but important components: reassurance, intervention, advice, explanation, in each of the four time periods.

I. Observation-The Timeless Constant of Patient Care

The period between 1859 and 1925 was regarded as an important era marking impressive changes in the manner in which physicians diagnosed patients. Development and implementation of diagnostic equipment including the ophthalmoscope (1851)²³⁸, laryngoscope (1855)²³⁹, thermometer (1865)²⁴⁰ and sphygmomanometer (1870's)²⁴¹ enhanced the physician's bedside clinical acumen. Urinalysis (1870's)²⁴², and later, pathologic specimens (1880's)²⁴³,

²³⁸Stevens, op. cit., p.39.

²³⁹Ibid., p.39.

²⁴⁰Temperature was a qualitative entity prior to the 1860's. Although thermometers did exist, they primarily recorded ambient temperature rather than the patient's. By 1865, patient temperature recording began to appear in patients' charts. By 1880, 80% of all the Massachusetts General Hospital's charts recorded this data point. Warner, Therapeutic Perspective, p.155.

²⁴¹Sphygmographic tracings began to appear in the Massachusetts General Hospital case records by 1870 and were routine by the end of the decade. Ibid., p.156.

²⁴²Although applied for specific diseases such as diabetes from the 1840's, microscopic urinalysis became common by the 1850's and routine by the 1870's. Ibid., p. 156.

²⁴³Autopsy analysis incorporated gross pathologic specimens into medical education from the early 1800's. Only towards the end of the nineteenth century did the addition of microscopic analysis launch pathologic histology. Students were exposed to mounting and preparative techniques as well required to assimilate the pathologic lesions. By 1901, pathologists acquired a unique identity within the medical field, forming their own professional specialist organization. Lester S. King, "Medicine in the USA: Historical Vignettes XV. Clinical Science Gets Enthroned, Part I", *JAMA*, vol. 250 (1983), pp.1169-1172; King Vignettes XIX, pp.219-224.

microbiologic cultures (1890's)²⁴⁴ and Roentgenograms (1895)²⁴⁵ provided the physician with objective data reflecting his patient's condition. Yet, despite these progressive technologic advances, one characteristic was continually valued and praised among physicians throughout the entire period: the ability to observe, with all five senses, a patient's every nuance and appreciate each sign's and symptom's relative contributions on the patient's overall condition. Each novel included sound observational techniques as an essential component to the good physician's repertoire.

Dr. DuBois, in Tale of a Physician, was endowed with "a quick intuitive judge of character. He...took with great swiftness a complete inventory of every feature and lineament in the strange, pale, rather handsome face of the tall, finely-proportioned sailor-looking correspondent"²⁴⁶. In another instance, "Wilson trembled from head to foot...This remarkable manifestation of nervous excitement in the young man did not escape the observant practiced eye of the physician"²⁴⁷.

Dr. Bryson's quick eye diagnosed Johnnie Ledgcott's croup at the dinner table. "'Why-' he exclaimed, turning suddenly towards Johnnie...Bryson sat looking steadfastly at Johnnie Ledgcott. 'What makes you breathe that way, Johnnie?' he demanded, fixing his keen eyes on the boy. Johnnie, struggling

²⁴⁴Although bacteriology enjoyed numerous scientific advances in the 1880's, the American physician recognized little practical experience. By the late 1880's, only the younger medical graduates versed in microscopy manipulated clinical bacterial cultures. However, by the early 1890's laboratory examination played an important and accepted role in the diagnosis of typhoid and diphtheria. Lester S. King, "Medicine in the USA: Historical Vignettes VIII. Germ Theory and Its Influence", *JAMA*, vol. 249 (1983), pp.794-798; King Vignettes XIX, pp.219-224.

²⁴⁵Paul B. Beeson, "One Hundred Years of American Internal Medicine", *Annals of Internal Medicine*, vol. 105 (1986), pp.436-444.

²⁴⁶Davis, Tale of a Physician, p.188.

²⁴⁷Ibid., p.235.

with a breath, tried to laugh apologetically...'Come here' commanded the doctor, brusquely. He stood Johnnie before him and watched his breathing"²⁴⁸.

Spearman repeatedly emphasized Dr. Bryson's keen vision and observational style and invoked these as focal components of the Doctor's conscientious style.

Dr. Rast similarly diagnosed a case of tuberculosis. While visiting the Rasts, "suddenly David coughed violently, and Ruth rushed to him in violent alarm, clutching his hand...The Doctor glanced up at them sharply. He understood in a flash. 'I guess, Nell', he said quietly, 'that you and Ruth had better wait outside. I want to see David!'"²⁴⁹. At the bedside, he harnessed his careful observational style. Examining Martha, an eighteen year-old with pneumonia, "he forgot the face in marking the symptoms. A deep red flush was in the center of each cheek; the expression of the face was weird with a mixture of anxiety and apathy; the eyes were brilliant; the nostrils dilated; the breath came in short expiratory grunts. A barely perceptible pulse beneath his fingers raced at a terrible speed; she was in high fever; and all the time she mumbled wild snatches of incoherence. His limbs seemed to get cold; the blood left his cheeks. In a flash he saw what he alone was facing"²⁵⁰. Dr. Rast's thorough appreciation for the patient's symptomatology inevitably led him to the correct diagnosis of pneumonia.

Dr. Nye's accurate observations enabled him to diagnose Mrs. Stone's typhoid where other physicians had failed. Previously, Dr. Parker suggested malaria, but "malaria was by no means common in Ostable"²⁵¹ Dr. Nye carefully

²⁴⁸Spearman, Doctor Bryson, p.89.

²⁴⁹Oppenheim, Doctor Rast, p.123.

²⁵⁰Ibid., pp.92-93.

²⁵¹Lincoln, Dr. Nye, p.93.

pondered that Mrs. Stone's "eyes were bright-almost too bright-so the doctor thought-and her face was flushed and her pulse rapid. Her temperature, so the thermometer disclosed, was a degree above normal...That afternoon he called again, found the fever higher, and the patient complaining of headache and backache. A suspicion, already formed in his mind, became stronger"²⁵². A microbiologic specimen only confirmed Dr. Nye's initial hypothesis: typhoid.

Observational skills also distinguished Washington Square's Dr. Sloper. "He had passed his life in estimating people (it was part of the medical trade), and in nineteen cases out of twenty he was right"²⁵³. The Doctor touted his own observational acumen. "What I tell you is the result of thirty years of observation; and in order to be able to form that judgement in a single evening, I have had to spend a lifetime in study"²⁵⁴. His observational skill forecasted his own death. "He came home with an ominous chill...he said to Catherine'...I shall not recover'...he had never been wrong in his life, and he was not wrong now"²⁵⁵. Dr. Sloper, during his analysis of Morris Townsend, demonstrated his method for organizing his observations. "The doctor was never eager, never impatient or nervous; but he made notes of everything, and he regularly consulted his notes. Among them the information he obtained from Mrs. Almond about Morris Townsend took its place"²⁵⁶.

²⁵²ibid., pp.92-93.

²⁵³James, Washington Square, p.66.

²⁵⁴ibid., p.41.

²⁵⁵ibid., pp.168-169.

²⁵⁶ibid., p.33.

Holmes metaphored Dr. Kittredge's observational skills through the physician's use of his spectacles. "When he was listening to common talk, he was in the habit of looking over his spectacles; if he lifted his head so as to look through them at the person talking, he was busier with that person's thoughts than with his words"²⁵⁷. While talking with Elsie Venner, "he lifted his head and dropped his eyes a little, so as to see her through his spectacles"²⁵⁸. He similarly examined Bernard Langdon. During a social visit, "all this time the Doctor's eyes were fixed steadily on Mr. Bernard, looking through the glasses"²⁵⁹. Upon the young teacher's departure, Dr. Kittredge summarized his observations. "The fellow's hand did not tremble, nor his color change. He is one of the right sort"²⁶⁰. Dr. Kittredge's quick observational skills enhanced his clinical acumen. Instantaneously, he determined the cause of Deacon Soper's choking paroxysm. "'He's not choking my friends', the Doctor added immediately when he got sight of him...'It's all right,' said the Doctor, as soon as he saw his face. 'The Deacon had a smart attack of neuralgic pain. That's all. Very severe, but not at all dangerous'...He had looked through his spectacles and seen at once what had happened"²⁶¹.

Drs. Kittredge, Bryson and Rast employed their five senses for diagnosis. Yet, the notion that restricted observation to the five senses was arbitrary and

²⁵⁷Holmes, Elsie Venner, p.98.

²⁵⁸Ibid., p.100.

²⁵⁹Ibid., p.211.

²⁶⁰Ibid., p.218.

²⁶¹Ibid., pp.115-116.

constraining²⁶². Dr. Holden earned the reputation of transcending this barrier by possessing an additional sixth sense. Dr. Percy explained Dr. Holden's extraordinary talent. "The doctor [Dr. Holden] is different...I've watched 'em,-big doctors at the hospitals and in the medical schools, here and abroad...but they can't touch our doctor! It isn't what he knows...but it's different from knowing, what he has...He understands bodies by some sixth sense we haven't any of us got, -sees what we could never find out with our five, -and then he cures-he really makes folks well...It is a kind of magic-like any other big gift. It's more than medicine"²⁶³. Dr. Holden finely honed his observational skills. He appreciated patient nuances missed by others and capitalized on these to better secure his cure. Using his sharp insight, he achieved a higher plane of goodness.

Attuned observational skills marked the good physician; lacking these skills denoted the lesser professional. Mitchell highlighted this point through Dr. Wendell. Among his many shortcomings, Dr. Wendell was discordant to the echoes of human nature. He failed to appreciate Edward Morton's refined, sensitive character. "There are delicate overtones of unselfishness which belong only to the purest and sweetest natures refined by the truest good breeding...The lad was full of them, but Wendell unfortunately was one whose sensibility to moral harmonies failed of hearing-power for these higher notes of the gamut of character...In fact, he was lost to the passing moments and was looking back upon a world of action and forward to a world of passive inactivity"²⁶⁴. His lack of

²⁶²Although advocating scientific inquiry, Suchman suggested that therapeutic relationships limited to the five senses place an artificial boundary between the mind and spirit. Opening this connection allowed for better understanding for a larger subset of emotions and experiences that were intangible to the five senses. Suchman, op. cit., pp.125-130.

²⁶³Herrick, Healer, p.188.

²⁶⁴Mitchell, In War Time, pp.59-60.

observational acuity contributed to his disqualification from ranking as a good physician.

II. Balancing Reassurance, Intervention, Explanation & Advice.

In the 1830's, Daniel Drake and his contemporaries began to actively describe those attributes of a physician's behavior considered essential for the proper practice of medicine. These qualities, influenced by Jacksonian rhetoric, were commonly ascribed to President Jackson himself. The good physician was supposed to embody "a native strength of mind, knowledge of mankind, integrity, judgement, and in general, a capacity to act"²⁶⁵. These attributes remained as the cornerstone for all future commentaries on the physician's necessary components. Reflected onto the doctor/patient relationship, these attributes translated into the four elemental components comprising any patient-physician interaction: reassurance, intervention, advice and explanation.

Reassurance or 'the native strength of mind' defined the physician's ability to comfort his patients through their suffering. Reassurance served to instill confidence in the physician's knowledge and skill. It also included the physician's ability to demonstrate character strength and equanimity even in the event of a poor prognosis or an unforeseen complication.

Intervention or 'in general, a capacity to act', referred to both the physician's technical skill and preparedness to apply these skills.

Advice or 'judgement' described the physician's professional sensibility and willingness to dispense his opinions to his patients. This category also encompassed the manner in which these recommendations were transmitted to the patient. Dispensing advice invoked a paternalistic doctor/patient

²⁶⁵Brieger, Classics and Character, p.96.

relationship²⁶⁶ with the patient placing complete trust in the physician's judgement.

Explanation or 'knowledge of mankind' involved the physician sharing with the patient relevant medical knowledge and insight concerning the patient's case and course of therapy. Effective employment of explanation carried two major assumptions. Firstly, the physician himself was expected to have studied and assimilated the requested 'knowledge of mankind'. Secondly, he required the patience to synthesize and simplify the information to meet his patient's capacity for comprehension, a 'knowledge' of his cross-section of 'mankind'.

In each of the four periods defined in this study, the novels incorporated all of these elements into the doctor/patient interaction. The authors defined each physician through prioritizing these techniques in his practice (e.g. a predominantly reassuring practice versus a highly interventative style). The good physician would perpetually distinguish himself by selecting the optimal balance among the four elements so as to maximize patient satisfaction.

Reflecting the evolving standards of medical practice, the preferred balance continually changed. Each period adopted a new standard to measure the good physician. Having compiled the novel's examples of successful and unsatisfactory doctor/ patient interactions, presented below are each period's reactions to the four individual elements as well as a synthesis of the good physician's ideal balance.

²⁶⁶The paternalistic model assumed that the physician's expertise permitted him to determine the patient's best interests with minimal patient participation. The patient would defer all judgments to the physician and blindly accept the advised course of therapy. The paternalistic physician would act as the patient's guardian. Ezekiel J. Emanuel and Linda L. Emanuel, "Four Models of the Physician-Patient Relationship", *JAMA*, vol. 267 (1992), pp. 2221-2226.

A. The 1860's

The 1860's physician agonized about his frustrated attempts at alleviating patients' suffering. He recognized his pharmacologic armamentarium to be grossly inadequate. Therapeutic 'skepticism', growing since the 1820's, reached its peak by the 1860's²⁶⁷. Its advocates, hailing predominantly from the Boston area, believed that active medical heroics often did more harm than good. They effected a more reserved, expectant management. Traditional heroic depletive therapies including antimonial emetics, bloodletting and mercurial cathartics declined in use at the Massachusetts General Hospital in the three decades preceding the 1860's²⁶⁸. More benign stimulatory therapies including quinine, iron and alcohol slowly gained acceptance through the 1860's²⁶⁹. Only opiates had already established themselves in the 1860's physician's pharmacopoeia²⁷⁰. Hesitant to intervene, the 1860's physician relied predominantly on reassurance for a reliable foundation to his professional relationship. The good physician valued a reassuring demeanor in allaying his patients' fears and anxieties of both frightening disease and debilitating therapeutics. "The physician whose face reflects his patient's condition like a mirror may do well enough to examine people for a life insurance office, but does not belong in the sick-room"²⁷¹.

²⁶⁷Warner, Therapeutic Perspective, p.17.

²⁶⁸In the Massachusetts General male medical wards the percentage of patients who received the following treatments in the 1830's, 1840's and 1850's respectively: antimonial emetics=22.0, 12.1, 6.8. bloodletting=34.8, 22.1, 14.3. mercurial cathartics=50.8, 41.4, 28.7. Ibid., p.30.

²⁶⁹Ibid., figure 14, p.144 and accompanying text [p. 145] for total percentages of cases at the Massachusetts General Hospital using these therapies.

²⁷⁰Ibid., p.137-figure 11.

²⁷¹Holmes, Elsie Venner, p.424.

Davis intimated that the physician's reassuring talents surpassed even the priest's in importance. "The diplomatized and established physician frequently took precedence over the venerated priest in the confidence of the family...In the privacy of the sick-chamber, when the stricken patient fears that the tide of life is fast ebbing away, the physician often becomes the recipient of confessions of vices, crimes, and misery, which the ear of the revered priest had never been permitted to hear"²⁷². The physician was frequently offered the final confessional. Yet, his responsibility transcended merely accepting this emotional outpouring; it included consoling his patient either into a peaceful passing or a calming convalescence.

Patients craved even the slightest reassuring gestures. "Wendell offered to sleep at the house until the major grew better, and his offer being gladly accepted, arrangements were made to send the carriage for him every night about ten o'clock"²⁷³. The comfort of having a nighttime attendant calmed the Mortons immensely. Withholding reassurance catalyzed patient anxiety. Physicianless, Mrs. Morton scurried about "Why do you suppose Dr. Wendell has not been here? I sent for him...he must know how intensely desirous I am to see him...I think he should have come. I want to feel more sure about him...I do not like his delay in coming here"²⁷⁴. The physician's professional obligation to reassure his patients surpassed all personal priorities. "Manners have a good deal to do with...success in medicine"²⁷⁵.

²⁷²Davis, Tale of a Physician, p.6.

²⁷³Mitchell, In War Time, p.54.

²⁷⁴Ibid., p.224.

²⁷⁵Ibid., p.17.

In characterizing the successful doctor/patient interaction, the 1860's novels stressed the physician's reassuring capabilities. Dr. Lagrange, despite his perfunctory military style, greeted each new hospital admission reassuringly. "The surgeon saluted the newcomer on his little palliasse, noting that around him lay a faded coat of Confederate gray with a captain's stripes on the shoulder. The wounded man returned the salute with his left arm. 'You were hurt at Gettysburg?'...the surgeon remained unmoved. 'I hope you will soon be well...see that this gentleman is put in Ward Two near a window...Come now, my men; move along! Who next?'...he bent to shake hands warmly with a sallow man who filled the next stretcher...and so the long list of sick and hurt were carried in, one by one...until, as night fell, the surgeon turned and entered the hospital"²⁷⁶. Dr. Lagrange's reassurance was ubiquitously present. Even with the enemy Confederate soldier his style never flinched.

Dr. Lagrange also displayed his reassuring style while his tending Major Morton's convalescence. His talents were most obvious when relegated to delivering an unpleasant prognosis. He began honestly. "'We don't quite like Morton's condition. He does not come up as he should do...he is in no immediate danger. We have only of late felt so uneasy'...'Are you sure you have told me the truth?'...'Yes so far as we know it'"²⁷⁷. Dr. Lagrange, however, softened the blow by reflecting Morton's perceived stagnation through his profession's limitations. "Physicians can rarely be certain. Those who are most wise are least apt to be so...I wish I could also [have a more definite prognosis], my dear lady. That is just one of the miseries of our profession. If it would make you feel easier to have anyone else to see him with us, I am sure nothing would

²⁷⁶Ibid., pp.4-5.

²⁷⁷Ibid., p.48.

be more agreeable to Dr. Wendell and myself"²⁷⁸. Dr. Lagrange opened the option for further consultation, a method to garner supplemental reassurance.

Foiled to Dr. Lagrange, Dr. Wendell lacked his mentor's unobtrusive reassuring style. Although his "manners were gentle and amiable"²⁷⁹, Dr. Wendell displayed gross insensitivity to the reassuring finesse. Edward Morton sought from Dr. Wendell reassurance concerning the quality of his crippled existence. Dr. Wendell, however, "walked in silence. He felt in a vague way for the lad but did not know what to say. He tried to put himself mentally, in this young fellow's place, but neither his experience nor his intelligence suggested to him just what he ought to say...he was possessed of none of that...genius of sympathy...He had left himself none of the vague consolatory doubts on which the over-questioned doctor is apt to fall back"²⁸⁰. Worse, Dr. Wendell was missing the equanimity essential to a reassuring tone. Stumbling on Edward's dead body, Dr. Wendell, "always impulsive and emotional, lost the self-control which the doctor commonly learns to keep in the face of the most abrupt tragedies"²⁸¹.

Dr. Morte, the abortionist foiled to Dr. DuBois's "generous and handsome face...kindled with excitement and...expressive eyes enlarged with the consciousness of a great unselfish truth welling up behind them"²⁸², frightened his returning patients with his blatantly nonreassuring tone. "So, so; come again

²⁷⁸Ibid., p.48.

²⁷⁹Ibid., p.17.

²⁸⁰Ibid., pp.58-59.

²⁸¹Ibid., p.213.

²⁸²Davis, Tale of a Physician, p.215.

eh? About three years and a half ago, I'm thinking, you disappeared from this hospital with your life, and in fair health; didn't you, Miss Molly Ruciel?' The unhappy creature, being suddenly subject to this familiar and contemptuous language, was too intensely annoyed and too profoundly mortified to speak. 'Oho! Oho! The pretty store-girl come again eh? Come for treatment, I suspect?...Don't trouble yourself Miss Molly. Your wealthy lover, the gallant Jack Blake, has been here. It's all fixed. The handsome villain paid all fees and left full instructions..."²⁸³.

Using a gentle demeanor combined with his profound understanding of human nature, Dr. Kittredge worked his reassuring style as a fine art. "The old Doctor was a model for visiting practitioners. He always came into the sick-room with a quiet, cheerful look, as if he had a consciousness that he was bringing some relief with him...an imperturbable mask of serenity, proof against anything and everything in a patient's aspect"²⁸⁴. Dr. Kittredge handled the most difficult patients with general ease. "The old Doctor often came in, in the kindest, most natural sort of way, got into pleasant relations with Elsie by always treating her in the same easy manner...encouraging all her harmless fancies, and rarely reminding her that he was a professional advisor"²⁸⁵. He manipulated his reassurance so subtly that the patient was only aware of its effects, not the process itself. The Reverend Mr. Fairweather, anxious from his overwhelming attraction to Catholicism, was also calmed by Dr. Kittredge's consultation. "Little as the Doctor had said out of which comfort could be extracted...A film of

²⁸³Ibid., p.193.

²⁸⁴Holmes, Elsie Venner, p.424.

²⁸⁵Ibid., pp.195-196.

gratitude came over the poor man's cloudy, uncertain eye, and a look of tremulous relief and satisfaction played about his weak mouth"²⁸⁶.

Advice, although not as prominent as reassurance, was also favorably sought in the 1860's doctor/patient interaction. Edward Morton considered dispensing advice as important as dispensing remedies. "I can see that it must be part of a physician's life to think of how he can teach the sick-I mean the crippled sick-to fill up the gaps which disease has made in their happiness"²⁸⁷. Dr. Kittredge's speech "was apt to be brief and preremptory; it was a way he had got by ordering patients"²⁸⁸-well accustomed to dispensing advice. Reverend Fairweather often sought Dr. Kittredge "as the old Doctor was his counsellor in sickness and almost everybody's confidant in trouble"²⁸⁹. Dr. Kittredge acknowledged his patrician relationship. "Don't you know you have always come to me when you've been sick or dyspeptic anyhow and wanted to put yourself wholly in my hands, so that I might order you like a child just what to do and what to take?"²⁹⁰. Yet, the Doctor freely gave Bernard Langdon advice concerning Elsie's crush. "Let me talk to you with an old man's privilege, as an adviser...There are things which I must not tell you now; but I may warn you. Keep your eyes open and your heart shut. If, through pitying that girl you come to love her, you are lost..."²⁹¹. Dr. Lagrange was candid regarding Morton's slow

²⁸⁶Ibid., p.406.

²⁸⁷Mitchell, In War Time, p.205.

²⁸⁸Holmes, Elsie Venner, p.314.

²⁸⁹Ibid., p.404.

²⁹⁰Ibid., p.405.

²⁹¹Ibid., p.214.

hospital convalescence. "He has rather a serious wound, and today a quick pulse and a little fever. I would rather he waited a few days-two or three perhaps"²⁹².

Doctors did not offer explanations except within the context of reassurance. Dr. Lagrange's digression to Mrs. Morton on Medicine's uncertainties was a prime example. Dr. DuBois, "the judicious and trustworthy physician kept his beautiful patient [Sofia] ignorant of everything"²⁹³. The wiser physicians did not hassle their patients with convoluted explanations.

The physician's interventative capabilities were also not included as a crucial component to a successful doctor/patient encounter. Invasive procedures captured an uncommonly negative light. Dr. Morte's abortion procedure left Mary Ruciel's "back...chafed by resisting medical operations. There were sufficient marks of cruelty on both her wrists, the effects of cords with which Dr. Morte had bound her during treatment"²⁹⁴. Dr. Morte's technical coarseness reinforced the indifferent attitude towards intervening. "'Damn bad luck, this hitch' growled the villainous Doctor Morte, as he let the pulseless wrist of the beautiful girl drop from between his fingers...the student looked agitated and was evidently alarmed...the Doctor with angry impatience..."²⁹⁵.

Dr. Kittredge, frustrated with the limitations of his contemporary therapeutic armamentarium, preferred not to intervene unless absolutely necessary²⁹⁶. "He gave less [medications] than certain poor half-taught creatures

²⁹²Mitchell, In War Time, p.20.

²⁹³Davis, Tale of a Physician, p.35.

²⁹⁴Ibid., p.199.

²⁹⁵Ibid., p.197.

²⁹⁶With respect to Dr. Kittredge's therapeutic reservations, one must consider the fact that Oliver Wendell Holmes, Sr. himself preached and practiced 'therapeutic nihilism'. Skeptical about the

in the smaller neighboring towns who took advantage of people's sickness to disgust and disturb them with all manner of ill-smelling and ill-behaving drugs. In truth, he hated to give anything noxious or loathsome to those who were uncomfortable enough already, unless he was sure it would do good-in which case he never played with drugs but gave good, honest efficient doses"²⁹⁷. The only other recorded physician intervention demonstrated Dr. DuBois's attempts to revive first the assassinated Captain Aragoni then Sofia's stupor. "The doctor pressed a powder of belladonna between the set teeth of the insensible man [Aragoni], and then he administered to the patient, experimentally something of mesmerism...The doctor cautiously approached the patient [Sofia]...raised his hand, and poised it in the air over her white face. Then he made a few passes through the air from her head to her feet...He continued to sweep his hand through the atmosphere over her prostrate form...Then the physician administered a remedy...then her eyes opened wonderingly...then, sorrowfully and imploringly, she looked upon the strange face that was beaming so tranquilly and so benevolently upon her"²⁹⁸. Dr. DuBois's cautiousness emphasized his uneasiness with intervention. Even Dr. Lagrange's surgical exploits on the wounded soldiers are absent from the novels.

B. The 1880's

By the 1880's the doctor/patient relationship shifted toward an interventative spirit. Anaesthesia notwithstanding, prior to the 1880's surgery

effects of standard heroic practices, Holmes advocated only sparingly using drastic measures such as leeching, catharsis and purging...Warner, Therapeutic Perspective, p.27.

²⁹⁷Holmes, Elsie Venner, p.426.

²⁹⁸Davis, Tale of a Physician, p.34.

was a traumatic, violent affair²⁹⁹ carried out in public amphitheatres. The establishment of the American Surgical Association in 1880 and the 1885 publication of the *Annals of Surgery* created an active force to promote the advancement of surgical knowledge. Internationally, Billroth pioneered stomach, laryngeal and pharyngeal surgery and Horsley advanced neurosurgery. Bostonian Fitz established the surgical diagnosis of appendicitis in 1886 whereas J. Marion Sims accessed the gallbladder in 1878. Caesarean sections significantly decreased in morbidity between 1876 and 1882³⁰⁰. Clinical laboratories began to establish the foundation of internal medicine. Blood counts, hemoglobin and hematocrit values became practicable in 1887³⁰¹. Intervention became appropriate in nonsurgical illnesses as well.

In the 1860's Claude Bernard promoted the concepts of internal homeostasis and capillary circulation³⁰², founding experimental physiology. These new data prompted clinicians to conceive therapeutics as specific physiologic antagonists. Young clinicians espoused a renewed optimism centered around the evolving concept of physiologic therapeutics. Justification for dispensing these new drugs would be based on science, not empiricism. Their targets would be specific, producing calculated effects. Importantly, these new therapeutics would be devoid of the traditional heroic depletives' stigmata.

²⁹⁹The removal of a femur sequestrum, a popular 1870's conservative operation, offered a cogent example. Although this operation preempted an 'above the knee' amputation, the procedure involved hammering, chiselling and sawing combined with a tremendous blood loss. Gert H. Brieger, "A Portrait of Surgery: Surgery in America, 1875-1889", *Surgical Clinics of North America*, vol. 67 (1987), pp. 1181-1216.

³⁰⁰Lyons and Petrucelli, *op. cit.*, pp. 531-533.

³⁰¹Lester S. King, "Medicine in the USA: Historical Vignettes XII. Clinical Laboratories Become Important 1870-1900", *JAMA*, vol. 249 (1983), pp.3025-3029.

³⁰²Beeson, *op. cit.*, pp.436-444; Lyons & Petrucelli, *op. cit.*, p.503.

Experimental science offered the promise of direct clinical application. Physicians could resume therapeutic intervention with renewed confidence.³⁰³

Dr. Sevier's main therapeutic thrusts resulted from taking decisive action. His response to Mrs. Richling's first call for medical attention featured some momentary hesitation but then decisive action. "'Who is her physician?...I don't know about going at once. This is my hour for being in the office. How far is it and what's the trouble?...Yes, that's a small part women pay for the doubtful honor of being our mothers. I'll go'"³⁰⁴. Once at the Richling bedside, the patient most highly valued her physician's ability to intervene. "On the fourth [day] she was in a very critical state. She lay quite silent during the Doctor's visit...immediately she exclaimed, 'Doctor save my life! You mustn't let me die! Save me for my husband's sake!...-save me, Doctor! save me!'"³⁰⁵. Dr. Sevier calmly replied "'I'm going to do it! You shall get well!"³⁰⁶. Mrs. Richling begged Dr. Sevier to intervene. As a matter of course, he accepted the gauntlet and complied to her wishes.

Patients valued Dr. Sevier's interventions. One lady structured her vacations as to maximally avail herself of Dr. Sevier's talents. "At daybreak, he

³⁰³Not all 1880's physicians optimistically supported the development of physiologic therapeutics. Critics were most concerned with the process of drug development. Although laboratory experimentation may point to an agent's therapeutic applications, this could only be definitively proven following trials in a clinical setting. They argued that empiric individual nuances of disease could not be adequately controlled for in the laboratory. Trials in the clinical setting could increase rather than alleviate suffering, mocking the physician's healing role. Complete reliance on scientific principles for dispensing therapeutics, critics voiced, would obviate the need for the physician's clinical judgment and run the art of medicine into obsolescence. John Harley Warner, "Ideals of Science and Their Discontents in Late Nineteenth-Century American Medicine", *Isis*, vol. 82 (1991), pp.454-478.

³⁰⁴Cable, Dr. Sevier, pp.11-12.

³⁰⁵Ibid., p.21.

³⁰⁶Ibid., p.21.

[Dr. Sevier] was summoned posthaste to the bedside of a lady who had stayed all summer in New Orleans so as not to be out of the good doctor's reach at this juncture. She counted him a dear friend, and in similar trials had always required closed and continual attention. It was the same now"³⁰⁷.

Dr. Sevier prioritized his caseload based on the urgency for requiring intervention. A Kentucky gentleman consulted Dr. Sevier for his wife's depressed mood. In the office, the visitor suggested that bereavement was her illness's underlying cause. "She cannot recover from the loss of our son...a young man,-one whom I had thought a person of great promise..."³⁰⁸. The gentleman was interrupted by a hurried German immigrant who presented his wife's case-"I yoost come in fun mine paykery undt comin' in to mine howse, fen-I see someting layin' on te-floor-face pleck ans a nigger's; undt fen I look to see who udt iss-udt iss Mississ Reisen!"³⁰⁹. The baker implored the doctor to examine his wife. Dr. Sevier rejoined two comments: to the German-"I'll be there in a moment" and to the Kentucky gentleman "I shall have to leave you"³¹⁰.

The Kentucky plantation owner, however, was not completely satisfied with the Doctor's emphasis on intervention. He excused the doctor but not without a tone of highbrow contempt. "'This is one of those cases where it is only a proper grace in the higher to yield place to the lower...I have a good deal of feeling, sir, for the unlettered and the vulgar. They have their station, but they

³⁰⁷ibid., p.192.

³⁰⁸ibid., p.69.

³⁰⁹ibid., p.70.

³¹⁰ibid., p.71.

have also-though doubtless in smaller capacity than we-their pleasures and pains.' The willingness was slightly overdone and the benevolence of tone was mixed with complacency. He waited for a response but the doctor merely frowned into space and called for his boots. 'I may not be gone long, if you choose to wait' said the physician rather coldly"³¹¹.

Dr. Sevier often intervened, even when not initially asked for his professional expertise. In the middle of a conversation with the Doctor, Richling coughed once. Nonchalantly, the doctor reached for a pen and wrote a prescription. "Here; get that and take it according to direction. It's for that cold"³¹².

Dr. Sevier so prided in his interventative skills that he was slighted when anyone hinted otherwise. Richling, in the throes of his final illness requested that Madame Zenobie come and nurse him. "'Why Richling, can't I nurse you well enough?' The doctor was jealous"³¹³.

Dr. Sloper's practice was also punctuated by activity and intervention. The Doctor hoped to eradicate his daughter's fancy for Morris Townsend. Rather than quietly reassure both himself and his daughter, the Doctor planned decisive action. He proposed a six month sojourn in Europe, expecting the time and distance to cool the romance³¹⁴. Dr. Sloper was astonished that his therapy had no effect. "You try my patience and you ought to know what I am. I am not a very good man. Though I am very smooth externally, at bottom I am very

³¹¹*ibid.*, pp.71-72.

³¹²*ibid.*, p.282.

³¹³*ibid.*, p.434.

³¹⁴James, *Washington Square*, pp.112-115.

passionate...I have been raging inwardly for the last six months...Do you mean that in all this time you have not yielded an inch?"³¹⁵. For better effect, he doubled the dose-an extra six months in Europe.

In The Undiscovered Country (1880), Dr. Boynton's dedication as a physician was questioned principally due to his inappropriate inactivity during times of medical crisis. After collapsing during the séance, "Egeria was forgotten; she might have been trodden underfoot but for the active efforts of Hatch, who cleared a circle about her and at last managed to withdraw the doctor from his auditors and secure his attention for the young girl"³¹⁶. Hatch was frustrated that the doctor's first response was not to tend his ill child but to continue to pontificate experimental outcomes. Dr. Boynton's continued indifference ("Oh, a faint, a mere faint...the facts established are richly worth all they have cost"³¹⁷) roused Hatch's anger further. Dr. Boynton was not troubled by his daughter's poorly progressing convalescence. "Well, no, I cannot say that she is [better]. She has had a shock,-a shock from which she may be days and even weeks in recovering...In some respects it is regrettable. But there are in this case other countervailing advantages...The whole episode on its scientific side, has been eminently satisfactory"³¹⁸. Dr. Boynton's image as a physician suffered from his unwillingness to assume an active, interventional role.

Dr. Boynton's professional transformation began as soon as he displayed a stronger inclination to intervene. Dr. Boynton displayed his first indications of a

³¹⁵Ibid., p.121.

³¹⁶Howells, Undiscovered Country, p.33.

³¹⁷Ibid., p.33.

³¹⁸Ibid., pp.48-49.

turnabout as he and Egeria trudged through the snowy Massachusetts landscape. "He asked abruptly, 'What's the matter Egeria?'...'I don't know. Nothing. I am not very well.'...'You ought to be, in air such as this. Let me see.' He caught up her wrist. 'Rather a quick pulse; it may be the walking. Are you hot?'...'My feet are cold,-they're wet.' He looked down at her shoes, and shook his head in a perplexed fashion. 'We must stop somewhere and dry your feet.'"³¹⁹. The doctor's initiative, however, was short lived. Once in the tavern, "her father found her feverish, and no better for the tea she drank. He fretted and pined at her condition, and then he grew tired of looking at her pale face...he went into the other room"³²⁰.

Arriving at the Shaker community, Dr. Boynton resumed his interventional efforts. "'I find my daughter in a fever', said Dr. Boynton with an absent air, 'What kinds of medicines have you in the house?...'They [herbs] may be the best thing', said Boynton with the same abstraction as if he were thinking of something else at the same time...'I have always taken care of her, and to-night at least I will watch with her...if her fever increases, she will wake at eleven and I will give her this"³²¹. Yet, the Shaker sisters noted Dr. Boynton's distracted indifference and questioned his ability to care for the girl. They witnessed Dr. Boynton watch "over Egeria in her sickness with the mechanical skillfulness and the mental abstraction...seen in his treatment of her case from the first"³²². Yet, "he was at the bedside night and day...he prepared the medicines himself and

³¹⁹Ibid., p.146.

³²⁰Ibid., p.151.

³²¹Ibid., p.171.

³²²Ibid., p.183.

administered them with his own hand, and he waited for their effect...with anxious scrutiny"³²³. His interventional diligence earned the community's respect for his professional qualifications. Nonetheless, focusing on his gestures' automaticity, the Shakers were convinced "as if there was somethin' better than duty in this world"³²⁴; that his motivations went beyond his daughter's convalescence.

Steadily, Dr. Boynton regrew into his professional role of 'healer'. Watching Egeria, his "efforts were bent not only to Egeria's escape from danger, but to her immunity from suffering, so far as he could avert it"³²⁵. He slowly shed his practice's mechanical overtones and incorporated emotion and caring into his efforts. With the spring, he recaptured some of his duties as a general practitioner. "He had treated several slight cases of sickness which occurred in the family; and he had drawn all the teeth in the head of a young sister much tormented with toothache"³²⁶. His therapeutic successes centered around decisive interventions. Offering his professional services to the surrounding farmhouses, Dr. Boynton completed his rediscovery and rejoined the medical ranks. "There was sickness in some of these forlorn places, and once it happened to the doctor to be able to afford relief in the case of a suffering child. He was very tender with it and gentle with the parents..."³²⁷. The crux of Dr. Boynton's

³²³ibid., p.183.

³²⁴ibid., pp.183-184.

³²⁵ibid., p.184.

³²⁶ibid., pp.185-186.

³²⁷ibid., p.197.

reaffiliation with the 1880's medical profession was his assumption of an active interventionalist style of practice.

Despite the emphasis on intervention, reassurance remained an important component of the 1880's doctor/patient encounter. Dr. Sevier's frequent curtness with patients was regarded as his Achilles' heel. Discussing the issue of remuneration; "'Dr. Sevier, I don't know what your charges are'-'The highest', said the Doctor, whose dyspepsia was gnawing him just then with fine energy. The curt reply struck fire with the young man [Richling]. 'I don't propose to drive a bargain, Dr. Sevier!' He flushed angrily after he had spoken...with the sort of indignation that school-boys show to a harsh master"³²⁸. Dr. Sevier realized his lapse and continued the conversation "with better self-control"³²⁹.

Dr. Sevier could effect a professional soothing tone. During his initial examination of Mary Richling, "his greeting and gentle inquiry were full of a soothing quality...his long fingers moved twice or thrice softly across her brow, pushing back the thin, waving strands, then he sat down in a chair continuing his kind, direct questions"³³⁰. He offered her malarious husband vibrant encouragement. "Come now my dear, you are making too much of a small matter. Why, what are chills? We'll break them in forty-eight hours"³³¹. During a subsequent illness, "his tone was full of cheer, but it was also so motherly and the touch so gentle with which he put back the sick man's locks...that Richling turned his face away in chagrin"³³². Even while discussing with the Richlings

³²⁸Cable, Dr. Sevier, p.13.

³²⁹Ibid., p.13.

³³⁰Ibid., p.19.

³³¹Ibid., p.135.

³³²Ibid., p.344.

their personal financial situation, "he spoke long, and as he had never spoken anywhere but at the bedside scarce ever in his life before...A soft love-warmth began to fill them through and through. They seemed to listen to the gentle voice of an older and wiser brother"³³³.

Nonetheless, on multiple occasions, he produced an unprofessionally cynical, flippant manner. On a subsequent visit to Mary, he was not as reassuring. "'You'll save me?', she whispered. 'Yes, we'll do that-the Lord helping us...I don't pray, but I'm sure you do'"³³⁴. By adding this last clause, he distanced himself from the sick lady and left her alone with the Lord to face her fears. Dr. Sevier, impatient with Reisen's verbose style, also snapped at the German baker. Reisen hoped to share with the Doctor his excitement from his bread-making patent, but Dr. Sevier, "consulting his watch, as he had already done twice before...'But what do you want to see me for? What have you kept me all this time to tell me-or ask me?'"³³⁵. Reisen was slightly offended.

By the 1880's, reassurance was intimately tied to intervention. Without active reinforcement, reassurance seemed vacuous. Traipsing through the snow, Dr. Boynton attempted to reassure Egeria of their predicament. "Don't cry, don't cry...we will walk on...or if not, we can't starve in a single night, and at this season we can't perish of cold"³³⁶. Without a course of action, these reassurances seemed absurd and Egeria remained inconsolable. However, when Dr. Boynton combined his reassurances with intervention, he obtained a better response.

³³³Ibid., p.157.

³³⁴Ibid., p.62.

³³⁵Ibid., p.298.

³³⁶Howells, Undiscovered Country, p.134.

Tending the febrile Egeria, "he often used his mesmeric power with what appeared good effect. The rendering headache yielded to the mystical passes made above her throbbing temples, or over her eyes that trembled with the hot pain; or perhaps it was only the touch of the physician's wise fingers that soothed them, and brought her the deep, strange sleep"³³⁷.

Dr. Sevier dispensed advice as an important component of his practice (although he was the only 1880's physician studied that did so). To Reisen, he suggested "I want you to pack your trunk, take the late boat, and go to Biloxi or Pascagoula, and spend a month fishing and sailing"³³⁸ to avert a nervous breakdown. Attending Richling's malaria, in addition to "a little medicine skillfully prescribed, the proper nourishment, two or three days' confinement in bed"³³⁹, he advised "'no, you'd better stay where you are today; but tomorrow, if the weather is good, you may sit up.' Then Richling, with the unreasonableness of a convalescent, wanted to know why he couldn't just as well go home. But the Doctor said again, no. 'Don't be impatient...it would be invaluable for you to spend your entire convalescence here, and go home only when you are completely recovered'"³⁴⁰. The Doctor also offered the young couple practical personal advice. "'John, do you remember what Dr. Sevier told us?' 'Yes, he said we had no right to commit suicide by starvation'"³⁴¹.

³³⁷Ibid., p.184.

³³⁸Cable, Dr. Sevier, p.304.

³³⁹Ibid., p.138.

³⁴⁰Ibid., p.138.

³⁴¹Ibid., p.201.

Explanation, although rare, had begun to develop its niche as a preamble to exploring new therapeutic modalities. Dr. Boynton included a solid explanation of his hopes for spiritualism. "Dr. Boynton included Ford also in his explanation. 'What we are about to do requires the exclusion of all light. These intelligences, whatever they are, that visit us seem particularly sensitive to certain qualities of light; they sometimes endure candles pretty well, but they dislike gas even more than daylight...'"³⁴². The young doctor who tended Dr. Boynton's head trauma also prefaced his treatment with an explanation. "It's a faint-I can't tell what it's complicated with. He received some contusions in his fall-about the head. He's an elderly man. He's stout...these apoplectic seizures are serious things for anyone after thirty. Still, it's a slight attack-comparatively. The contusions-I'm obliged to leave him for another patient just now. I shall be back again directly"³⁴³. His motivations for explaining-to discuss pathophysiology, to justify a prognosis and to present selected treatment modalities-would be popularized in the next twenty years.

C. The 1900's

Clinical science was founded on the principle of "the careful study of a few patients; the use of advanced tools of discrimination to identify *process*;; the formulation of *general principles* regarding the disease in question"³⁴⁴. The ensuing clinical science expansion progressively endowed the early twentieth-century physician with experimental data explaining disease etiology. This

³⁴²Howells, Undiscovered Country, p.29.

³⁴³ibid., pp.268-269.

³⁴⁴Lester S. King, "Medicine in the USA: Historical Vignettes XVI. Clinical Science Gets Enthroned-Part II", *JAMA*, vol. 250 (1983), pp.1847-1850.

accrual of knowledge, however, produced conflicting effects on the doctor/patient relationship. Physicians were equally eager to reinforce their diagnoses with scientific fact as patients expected thorough elaborations on their ailments. Yet, science erected a barrier between physician and patient, separating the aware and the ignorant. The social distance between doctor and patient progressively increased between 1880 and 1900³⁴⁵. Incumbent on the good physician was the responsibility to minimize this gap. Explanation, offering this opportunity, acquired a prominent place within the doctor/patient encounter.

Dr. Bryson assumed the responsibility of explaining glaucoma to Mrs. Eliot and June Borderly.

"What's the matter with it [Ruth's eye], doctor?', demanded June Borderly

'Glaucoma'

'What's glaucoma?' He looked wryly at her. 'A very troublesome thing.'

'Can't you do anything for it?', asked June, bluntly.

'Something may be done for it', he answered slowly. 'We can't always say whether what is done will do any good'"³⁴⁶.

He followed this with a more substantiative scientific background. "But what is glaucoma, Doctor?' 'Frankly, I don't know. If we knew-if we really knew. I can give you the definition, anybody can do that. The fluids that feed the eye fail to discharge; the ball becomes tense from inward pressure, just as you might fill a toy bladder to bursting. The delicate coatings of the retina are torn and detached by the ever-increasing pressure. The eyeball becomes hard-stony hard; the optic nerve is cupped into its canal-the field of vision gradually narrows-sight flickers like a sinking candle-dies. We call it glaucoma'"³⁴⁷.

³⁴⁵Melissa McBain, Ideal Physician in Drama, pp.72-80.

³⁴⁶Spearman, Doctor Bryson, pp.24-25.

³⁴⁷Ibid., p.40.

Dr. Bryson considered it incumbent on the physician to explain diagnoses and procedures. He was astonished that his colleague Dr. Kurd failed to do so. Mentioning that Dr. Kurd had consulted him earlier in the day regarding the child's proposed iridectomy, the ladies questioned him on the procedure. "Didn't Kurd explain?", asked Bryson, looking at Mrs. Eliot. 'He spoke of an operation, but he did not explain'"³⁴⁸. Dr. Bryson's compassionate nature prompted him to fill in this gap as well; "an iridectomy is a delicate and complicated operation to open up the drainage canal of the eye and relieve the excessive interior pressure"³⁴⁹.

Even while performing an emergent procedure Dr. Bryson offered an explanation. Tensely monitoring Johnnie Ledgcott's progressive respiratory distress, Dr. Bryson still offered an unhurried, honest appraisal of the boy's condition and prognosis. "The inflammation is severe. It couldn't be worse. His heart is acting badly. I am trying to force it. You can tell...almost as well as I can whether it will hold up for twenty-four hours. That's all on earth there is to it. He's getting enough oxygen yet, but it costs the heart a frightful price"³⁵⁰.

Dr. Holden founded his early backwoods practice on the tenet of honest explanation-"I told them the truth, and that's why they began to come to me from the ends of the earth"³⁵¹. Completing his examination of Nell's head trauma, he followed his own example. "Anybody could see what's the matter...your daughter has a cerebral hemorrhage-pressure here!...Paralysis has

³⁴⁸Ibid., p.27.

³⁴⁹Ibid., p.27.

³⁵⁰Ibid., p.101.

³⁵¹Herrick, Healer, p.383.

set in already. You can see yourself that her limbs are numb and her eyesight is affected"³⁵². Although the ominous prognosis launched Mrs. Goodnow into hysterics, Holden's anatomical perspective soothed Nell. She appreciated Dr. Holden's directed approach, called him back into the room and demanded "'Tell me everything'. And in a few words he described the thing to her, what had happened, what must happen to her soon unless the miracle came; also the operation he had advised,-the cutting of the skull, the relief of the spot of pressure on the brain-all. She listened intently, and when he had finished she bent her head simply as a child might proffer a hand to have a splinter taken out, saying:-'You will do it for me?'"³⁵³. His open, honest explanations gained him patients', like Nell's, confidence and trust.

Dr. Rast also incorporated explanations into his practice. He responded to his patients' angst for diagnostic and prognostic details. Yet, considering his immigrant community's level of sophistication³⁵⁴, he used them more sparingly. He shared with Martha's family: "William-here's the truth. She has pneumonia-this is the seventh night-the crisis night-it's a fight-a terrible fight and then-God knows! Brace up, William!"³⁵⁵. Dr. Rast understood that his

³⁵²ibid., pp.11-12.

³⁵³ibid., p.15.

³⁵⁴Eastern European Jewish Immigrants were often unfamiliar with Western medicine. The prohibitive costs of consulting physicians in the old country forced Jews to rely on home remedies and local folk healers. The traditions continued on New York's Lower East Side. Physicians were called only for the gravest of emergencies. Yet, once arrived, the family bestowed on the physician the utmost of respect. This testimonial mirrored Dr. Rast's reception. "He sits in state while the family stand about him. His instruments, his learning, his foreign appearance and manner-he is usually a Gentile or a highly assimilated Jew-inspire wonder and uneasiness...". The immigrant Jewish population was simple. Rather than grasping contemporary Western medical developments, they judged their physicians by "the warmth of their manner and the bitterness of their medicine". Alan M. Kraut, "Healers and Strangers: Immigrant Attitudes Towards the Physician in America-A Relationship In Historical Perspective", *JAMA*, vol. 263 (1990), pp.1807-1811.

³⁵⁵Oppenheim, Doctor Rast, pp.94-95.

community was more responsive to directed advice. Consulting a patient with moderately progressing tuberculosis, he plainly mentioned that "it's gone far-too far"³⁵⁶ and withheld scientific detail. Rather, he proposed a course of action.

"'How long', the Doctor asked quietly, 'has this been going on, David?'...'Three months!'...'And you did nothing! Three suicide-months! David, and you've been killing yourself! I thought you had more sense than that!'...The Doctor's face was a study in compassion; but he leaned close and spoke harshly. 'Fight, David, fight! Grit your teeth and face the music!...We must send him off to the country; we must let him get well; we'll send him somewhere up in Sullivan County...We'll keep him there till he's well again!'"³⁵⁷. Dealing with Ritzpah, a young dejected Socialist suddenly hysterical with a hemorrhage to the eye, "the Doctor seized her arm and spoke strongly: 'Sit down-quietly. You can't fight this by struggling! Come! This is only a hemorrhage-a spasm-it will pass! Come!'...He spoke roughly and harshly: 'If you are what you claim to be-not just a woman-show it now! This is a little realer than fighting with your tongue-than denouncing Wall Street. Fight with your worst enemy-Self. Quick now, do as I say!'"³⁵⁸.

The establishment of the medical specialties, each with their own collection of innovative techniques, expanded the importance and prevalence of medical interventions. Patients' welled with gratitude following successful procedures. "The little old woman was helped from the table [following cataract removal]...'my mother says thank you'...They turned to Bryson. He laughed as the hands of the old one, guided by her daughter's closed over one of his. Trying

³⁵⁶Ibid., p.125.

³⁵⁷Ibid., pp.124-125.

³⁵⁸Ibid., pp.283-284.

to speak, she could not, but bending she kissed the hand that had touched her eye that she might see"³⁵⁹. Moreover, patients came to expect an intervention each time they consulted a physician and expressed disappointment when this was not met. "Instances of famous medical men who had established their cures at remote places, and brought the sick to them from all parts of the world. 'These days, people like to run about, if they have money and an excuse. They'll go thousands of miles for a good thing"³⁶⁰. The good physician included decisive, timely interventions in most patient encounters.

In the operating room, a definite, crisp gleam characterized Dr. Bryson's surgical technique. "The delicate blade in his hand was already slipping through the insensible cornea-splitting it, deftly, as a butcher splits a kidney. It went all with care, yet steadily. Shimmering instruments, delicate manipulation, eager sponges, weaving fingers, low voices...bending close, passing and taking instruments and sponges, and at last he handed something to the head nurse on a bit of cotton and straightened up like one whose back tires, wiped his fingers on a napkin, threw it into the wire basket on the floor and watched the assistants bandage the eye...the surgeon of the eye"³⁶¹. Dr. Bryson's glory as an ophthalmologist stemmed from orchestrating the stainless steel surgical instruments, sutures, sponges and other apparatus into a neat, curative procedure.

Dr. Bryson's deftness and swiftness also carried his management of Johnnie Ledgcott's croup. "It was not a failing of Bryson's to lose time in a fight or go into it with ordinary measures. He brought in his best regiments at the

³⁵⁹Spearman, Doctor Bryson, pp.36-37.

³⁶⁰Herrick, Healer, pp.185-186.

³⁶¹Spearman, Doctor Bryson, p.36.

beginning. In a critical case he was a whirlwind, and in the sick-room, a despot...two great vaporizers were blazing...the two doctors looked, felt, auscultated, looked again...a thermometer hung from the fixture over the table and another was tied...to the brass spindle of the bed...the vaporizers poured the incenselike odor of compound tincture of benzoin...At one o'clock, Bryson, a sleeper trained to wake at will on the hour, rose from the couch, stretched himself before the grate, bent over Johnnie a minute...he watched the labored expansion of the chest...he took from the table a candle, and holding it close, noted the color about the lips and nostrils...Bryson-silent, active and ignoring the desperate conditions-wrung the steaming cloths about Johnnie's neck unceasingly..."³⁶². His calmness during the child's intubation was unmatched. "The surgeon and the nurse began almost at once the delicate and difficult operation. With their efforts, weakness, fright, suffocation mastered the child. He resisted convulsively, and became unmanageable...Bryson coaxed and pleaded and attempted again and again to make the insertion...his hair was tumbled, his shirt flecked with blood, his forehead pale and dripping sweat"³⁶³. The IV placement was equally smooth. "The doctor stepped silently to the table, and, taking up a delicate instrument, went to the boy, bared his arm, raised its flesh between the fingers of the left hand, pricked the needle into the white skin..."³⁶⁴. Both the case's difficulty and the physician's struggle were highlighted, emphasizing the required dexterity to successfully accomplish the task.

Dr. Holden adopted a similar nonplussed, calm attitude while performing interventions. After Nell had assented to Dr. Holden performing the

³⁶²ibid., pp.93-98.

³⁶³ibid., pp.103-104.

³⁶⁴ibid., p.105.

neurosurgery, the Doctor calmly and assuredly answered "Yes, I will do it"³⁶⁵. This calm but sure-footed style pervaded Dr. Holden throughout the entire procedure. "'Take that woman [Mrs. Goodnow] from the room', he said...peremptorily. 'Let the girl have quiet!...You,' he said to the little doctor, 'come with me. I shall need you'. Suddenly, with that decisive 'yes', he had become another man, no longer indifferent, hesitant, timid, but commanding and assured"³⁶⁶. Only the good doctors projected this collected demeanor.

Dr. Rast's interventional style casted him in the image of a fierce warrior in a raging battle. Following a difficult forceps delivery, "he showed the marks of the struggle, for he trembled as he hurried along. It had been a very great fight-the victory shifting to and fro. Time and again he hurled himself in with all the strength of his soul, and recoiled, dazed, baffled, half-conquered...So he got as it were his second wind, and with every nerve alive, his head clear, his hands precise and quick, he fought face to face with the enemy. He had to win-so he did win!"³⁶⁷. Again, in fighting pneumonia's seventh-night crisis, "he glanced a moment at the flushed beautiful face, at the playing feverish hands, the brilliant unseeing eyes. Then, quickly, he pushed an arm under her neck, lifted her head, and forced a swallow of whiskey through her lips...He drew the tank to the bed, put the rubber glass-tipped tube to one of the girl's nostrils, and applied the oxygen...And then the routine of the fight was established...he held to his course. It ceased to be a personal matter. The girl on the bed was merely an organism, a mere body. He watched it closely, following heart and pulse action, the flickering of the temperature, the change of expressions. Every ten or fifteen minutes he

³⁶⁵Herrick, Healer, p.15.

³⁶⁶Ibid., p.16.

³⁶⁷Oppenheim, Doctor Rast, pp.25-26.

applied oxygen. He replaced ice-bag with ice-bag...He administered stimulants. Not for a moment was he idle. His face was white and dripped sweat. His back and arms ached unendurably. He flung himself back to the fight time and time again-now recoiling exhausted, dazed, nerve nearly lost-now hurling himself back with every ounce and grain of power in him"³⁶⁸. Dr. Rast's heroics matched his contemporaries' ideals. "He fought only as a modern Doctor can fight. He fought with exactness, with mad energy, with heroic purpose...he fought on-and on-and on-at times almost exhausted, almost despairing...he felt already that he had reached the limit of his power"³⁶⁹.

Yet, Dr. Rast did not punctuate all of his interventions with blazing glory. His most poignant actions stemmed from tenderness and compassion. The tuberculous "David staggered to his feet and started blindly for the door. But there was a quick movement, and suddenly the big Doctor gathered his frail shattered body in his arms; the boy's head went down on the linen shirt, and the big man spoke as softly, as tenderly as a woman"³⁷⁰. While Dr. Rast's heroics are reminiscent in the constant referral to his bigness, it is the womanly tenderness that offset this particular intervention.

"Among the orthodox were many specialists-for the eye and the ear, the nose and the throat, the feet, the head, the heart, the skin, the lungs, the intestines. Man's body was divided into numerous small principalities, and each province had its special priest or butcher or nurse. And these only of the strictly regular, orthodox sects of healer-legally permitted to hang out their trade signs and invite patients to submit themselves to their science, to patch and prescribe

³⁶⁸Ibid., pp.98-100.

³⁶⁹Ibid., p.100.

³⁷⁰Ibid., pp.124-125.

for them and charge fees"³⁷¹. The rise of the medical specialties placed an extra variable in seeking medical intervention; which physician was best suited to perform a selected procedure. No longer could any doctor opt to perform a selected intervention. Every intervention had its specialist; both physicians and patients alike expected only designated specialists to engage specific procedures. Physicians straying from these boundaries generated suspicion and confusion.

Dr. Bryson reflected upon his physician's schedule. "...The month he had operated on the eye of a Montana copper man...Could that child's [Ruth's] eye be saved?... A wall-eyed boy was brought forward. The doctor took him in hand, and beginning with his usual talk on divergent strabismus...He worked hard and fast till eleven o'clock. The next hour went to his private practice..."³⁷². Each of Dr. Bryson's professional activities reflect his specialty. He operated on cataracts³⁷³ and glaucoma³⁷⁴. He was consulted on shrapnel lodged in a steel miller's eye³⁷⁵.

A rail passenger's incidental injury reflected the highly carved interventional niches of the various medical subspecialties. The young traveller displayed "a piece of adhesive plaster cover[ing] a wound above his right eyebrow; the eye itself was inflamed...'I was sitting in the smoking-room of the sleeper, and when we were pulling into town this morning some kid threw a stone through the car window and a piece of glass struck me right over the eye.

³⁷¹Herrick, Healer, p.404.

³⁷²Spearman, Doctor Bryson, pp.53-55.

³⁷³Ibid., p.35.

³⁷⁴Ibid., p.64.

³⁷⁵Ibid., p.34.

The company surgeon at the depot fixed up my forehead. I bled like a pig for a while, and then he sent me over here in a cab to have you see whether there was any glass in my eye"³⁷⁶. The railroad surgeon readily patched up the passenger's forehead but felt that an eye exam was beyond his jurisdiction.

During Ruth Eliot's iridectomy, the specialists' division of interventative responsibility is reflected within the presurgery preparative measures. "Dr. Bryson...was washing his hands...the head nurse helped him into his gown...The surgeon that was giving the chloroform lift[ed] the mask from Ruth's nose and retract[ed] and eyelid with his thumb...He lift[ed] the child's hand from it side and let it drop, stud[ied] its pulse, observ[ed] its respirations and nod[ded] towards Doctor Bryson, who was coming forward...Bryson bent over the operating table and look[ed] intently at Ruth, while the surgeon giving the anaesthetic told him of her pulse"³⁷⁷. As the eye surgeon, Dr. Bryson was exonerated from monitoring the patient's vital signs. A different specialist, the anaesthesiologist governed this province in addition to administering the gases.

Dr. Rast, although educated at Columbia's College of Physicians and Surgeons, was a generalist and limited his practice accordingly. He treated tuberculosis³⁷⁸, two cases of pneumonia³⁷⁹, and a mild ocular hemorrhage³⁸⁰. He delivered a baby³⁸¹. He dealt with the losses of an attempted suicide³⁸² and a

³⁷⁶Ibid., p.229.

³⁷⁷Ibid., p.63.

³⁷⁸Oppenheim, Doctor Rast, p.125.

³⁷⁹Ibid., p.52 & p.105.

³⁸⁰Ibid., p.282.

³⁸¹Ibid., p.26.

³⁸²Ibid., p.166.

sunken ferry boat which drowned one thousand Lower East Side lives³⁸³. He celebrated a golden wedding anniversary³⁸⁴ and witnessed the passing of a contented old man³⁸⁵. Excepting the ocular hemorrhage, the necessary interventions did not require the specialist's expertise. Dr. Rast did not tempt the boundaries and yet established himself as a good, respected community physician.

Dr. Holden challenged the specialist's boundaries and confused the medical hierarchy. Appreciating the urgently emergent nature of Nell's condition, Dr. Holden volunteered to perform the required neurosurgery. Mrs. Goodnow categorically refused. She wanted a bona fide neurosurgeon to operate on the brain. No other physician or surgeon, from her perspective, would be sufficiently qualified to guarantee success³⁸⁶. She had "always been used to the best doctors-of good standing"³⁸⁷. Nonetheless, Dr. Holden's determination triumphed and he performed the controversial operation. The precision, talent and crispness with which he operated resembled Dr. Bryson's highly qualified expertise. "They cut away her hair, turned back the flesh in a little flap...then the bone, until the brain lay itself bare...He worked so swiftly, so surely, without a word, a spare movement of hand or eye...When it was all over...he came back for a moment...devouring her with those piercing eyes, counting heart beats"³⁸⁸.

³⁸³Ibid., p.229.

³⁸⁴Ibid., p.75.

³⁸⁵Ibid., p.315.

³⁸⁶Herrick, Healer, pp. 12-13.

³⁸⁷Ibid., p.25.

³⁸⁸Ibid., pp.23-24.

The city neurosurgeons, having journeyed to the encampment for the consultation, were completely dumbstruck. Dr. Jenks exclaimed that "Not five men I know of on this side of the water could perform that operation properly. And you had the luck to find a sixth up here in the wilderness-marvellous, indeed"³⁸⁹. A younger neurosurgeon candidly expressed the overbearing question: "Where does he practice-keep his hand in? A thing like that can't be done off the bat, you know"³⁹⁰. Since specialists had compartmentalized each intervention, the medical establishment could not fathom a nonspecialized physician practicing sophisticated medicine. Yet, had Dr. Holden not intervened, paralysis and blindness would have established themselves while Mrs. Goodnow waited for the appropriate specialists. Although specialization may have promoted the creation of many good individual physicians like Dr. Bryson, it may have weakened the profession as a whole by establishing obstacles in the practices of generally talented physicians, like Dr. Holden.

Reassurance continued to feature prominently in the doctor/patient relationship. Dr. Rast's practice was best described as soothing. He approached the sickly Esther, a child of eight, "Come, Esther, it's Dr. Rast! Show me how brave you are. Come! There's my little girl!"³⁹¹. Attending Martha's pneumonia, "he leaned close, softly feeling a wrist...his busy, cool professional manner was reassuring and calming"³⁹². His reassuring nature established him as the community's dependable pillar. Following a suicide attempt, Dr. Rast sought to

³⁸⁹Ibid., p.25.

³⁹⁰Ibid., p.25.

³⁹¹Oppenheim, Doctor Rast, p.49.

³⁹²Ibid., p.92.

establish for the young lady a support network. "The Doctor thought quickly; the crisis had to be faced; the fight for her life had only begun...'Who is there who can speak to her? Any relative?'...'Relatives?...She hates them!'...'Any friend then?'...'She has none'...'The Rabbi!'...'We don't believe in God'...The Doctor's brain could think no further. It all came back to himself; there was no one else...Would Annette have gone out into nothingness, if he had not interposed"³⁹³. While his professional expertise placed him on the lofty pedestal of 'Doctor', his reassuring demeanor lowered him to the reachable level of 'human being'. His patients eager craving for Dr. Rast's humanity was best summarized by a dying but content old man. "Listen, do you mind my having asked you here? I don't need-I don't want a doctor. I want a human being-a man-and you, Doctor, are the only one I know down here-the only one who can speak with me and understand"³⁹⁴.

Dr. Holden invoked reassuring phrases and gestures as part of his healing regimen. While he tended Nell's convalescence, his attentive care established a unique doctor/patient bond. "Patient and doctor must go down together into the trough of despair...and meet there the darker enemies of life...the doctor kept his patient apart from the others, took her in his canoe up the lake on little expeditions where she might lie in solitude and drink in the healing light undisturbed...where the will of the physician was calling to the will of his patient"³⁹⁵. Dr. Holden possessed a unique appreciation for the importance of reassurance in a therapeutic encounter. "He understand bodies by some sixth sense we haven't any of us got,-sees what we could never find out with our five,-

³⁹³Ibid., pp.164, 166.

³⁹⁴Ibid., p.307.

³⁹⁵Herrick, Healer, pp.30-31.

and then he cures-he really makes folks well! Why, we had cases this last month of double pneumonia that would have died in any city hospital-and they are almost well...It's a kind of magic...It's more than medicine. It's will-pure will"³⁹⁶. This will was evident as he attended an outcasted mulatto woman, "a miserable, wasted creature...wretchedness...greasy black hair...emaciated"³⁹⁷. Yet, Dr. Holden "seemed wholly oblivious of the woman's squalor, and touched her dirty flesh softly as he might fine silk. When the sick woman was racked with a sudden spasm, he held her in his firm grasp until she shrank exhausted"³⁹⁸. Treating the forest communities, "the doctor did not seem to see this misery, to feel the meanness of these hovels. The dirty, ugly human bodies he touched with his delicate fingers as though they were fine and precious...'The sick are weak. They worship strength. They look for some power from without themselves to work a miracle...I am their nearest chance of the miracle"³⁹⁹. His kind, gentle reassuring touch coaxed and encouraged his patients back to health; the Doctor's poorly characterized 'will'.

Dr. Bryson relied on reassurance, especially when examining and treating children. While examining Ruth's eye, he guided and cajoled her such that she remained still and calm throughout the entire examination. "'You sit here, Ruth', suggested Doctor Bryson, confidentially, placing her on the other stool...He drew Ruth's stool closer to the lamp and laid one hand on her curls...Presently, he drew Ruth closer. 'How was your roast beef at dinner

³⁹⁶Ibid., p.188.

³⁹⁷Ibid., p.113.

³⁹⁸Ibid., p.114.

³⁹⁹Ibid., p.118.

tonight, Ruth? tough?'...'Yes, sir.'...'Real tough?'...Doctor Bryson covered Ruth's left eye with a blotter and held the fingers of his right hand up and back...'How many fingers can you count, Ruth?'...'Not any.' He was holding up three, but he stopped and said, 'Very good, Ruth'...'That's all. You're a brave little chick. And you have very sweet eyes; but one is very sick'⁴⁰⁰. He offered Johnnie Ledgcott the same reassuring calmness during his final paroxysm. "'Mamma!...I'm-choking!'...'No, Johnnie...Don't be frightened, Johnnie. I'll take care of you...Now Johnnie, here's something that will help you...'"⁴⁰¹. The child implicitly trusted Dr. Bryson's gentle manner, removing the loneliness from his dying hours.

D. The 1920's

The 1920's, marked the culmination of medical compartmentalization with the firm entrenchment of the medical specialties. Prioritizing intervention privileges evolved from an unwritten gentleman's agreement among physicians. The creation of specialty boards in 1910's and 1920's⁴⁰² began to establish a legal precedent limiting most interventions to boarded specialists. The generous private research endowments ensured a proliferation of scientific data which physicians eagerly incorporated into their practices. This exponential expansion in both the physician's interventional and explanative capabilities

⁴⁰⁰Spearman, Doctor Bryson, pp.23-24.

⁴⁰¹Ibid., p.97.

⁴⁰²The National Board of Medical Examiners was established in 1915, providing general medical certification. In 1916, Ophthalmology established the first specialty board. Otolaryngology followed suit in 1924. The American College of Surgeons, established in 1913, did not offer a formal 'board'. However, they elected fellows subsequent to rigorous screening, assuring members' highest competence. Specific postgraduate training requirements (1 year internship, 3 years as an assistant, 50 case abstracts and visits to surgical clinics) as well as an examination were required for fellowship appointment. Stevens, op. cit., pp. 92, 113, 126, 158.

produced a reactionary response in their patients. Patients still requested the best interventions and the most thorough explanations. However, patients grew weary of able physicians resting on their technical laurels. They reaffirmed their craving for the physician's personal touch. Reminiscent of the 1860's, reassurance regained its position as patients' most valued aspect to the doctor/patient relationship.

In spite of his blighted social position, Dr. Nye slowly recaptured Ostable's admiration by combining crisp intervention with gentle reassurance. Faith Copeland, overcoming her family's prejudice, preferred his kind style. "It is you, Doctor Nye, isn't it? I am glad...You are going to be here now, aren't you? Father said you were, while Dr. Parker is sick...I am glad. Tom [Stone] thinks you are a wonderful doctor"⁴⁰³. Miss Dana, the attending nurse also preferred Dr. Nye's demeanor over Dr. Parker's. "But I would rather not ask him [Dr. Parker], or even tell him unless it is necessary. He is such a-such a fuss. I never worked for such a-There! I mustn't say that...I was with you on Mrs. Stone's case and-and you are so different...I know I shouldn't say it; but you are, just the same"⁴⁰⁴. Eventually the town rediscovered Dr. Nye's refreshing approach to patients. "There must be something good about Ephraim Nye...Mrs. Johnson said he cured her bronchitis when Dr. Parker only made it worse. And we all know how he pulled Faith Copeland 'round after that accident. And he fetched Cyrenus's wife through her typhoid. And the Cashes and the Dacostas and the Roses and all their tribe swear by him...there must be somethin' to him all the same"⁴⁰⁵.

⁴⁰³Lincoln, Dr. Nye, pp.165-167.

⁴⁰⁴Ibid., pp.149-150.

⁴⁰⁵Ibid., p.223.

Keyes explored the reassuring physician's role by foiling David Noble to both Bobby Hutchinson and Fleursy's 'monsieur le médecin'. Dr. Hutchinson described himself as a "general practitioner-obsolete as hoop skirts and stove-pipe hats"⁴⁰⁶; he "pampered his patients"⁴⁰⁷. Hoop skirts and stove-pipe hats (the latter immortalized by Abraham Lincoln) belonged to the 1860's, the decade emphasizing reassurance. However, patients responded to Dr. Hutchinson's 'archaic' priorities. He had the uncanny ability to cure most of his patients. David Noble "sneered at the doctors who 'coddled their patients by lying to them'"⁴⁰⁸. He offered his patients the steady iciness of both the surgeon's knife and smile. His patients, devoid of reassuring after-care⁴⁰⁹ suffered nervous collapse six months postoperatively⁴¹⁰. Monsieur le médecin, "the shabby village doctor"⁴¹¹, deferred to Dr. Noble's surgical expertise. "I will return when you need me, but there is nothing I can do here now-but I obtrude my clumsy presence on your genius, monsieur"⁴¹². The country physician, however, assumed an equally important responsibility. "I will go downstairs, and try to comfort Mère Thérèse-the poor woman has made no sound, but her heart must be breaking for her granddaughter"⁴¹³. Absorbed by the trauma's urgency, Dr. Noble forgot about the

⁴⁰⁶Keyes, David Noble, p.177.

⁴⁰⁷Ibid., p.244.

⁴⁰⁸Ibid., p.233.

⁴⁰⁹Ibid., p.179.

⁴¹⁰Ibid., p.244.

⁴¹¹Ibid., p.227.

⁴¹²Ibid., p.227.

⁴¹³Ibid., p.227.

terrified, waiting family. Monsieur le médecin did not. At the novel's conclusion, a maturer Dr. Noble reprioritized his career. Intervention was no longer paramount. He mused that instead of chasing European surgical greats, "do you [Jacqueline] suppose that monsieur le médecin would take me for a partner? I'd have the time of my life practicing in Fleursy"⁴¹⁴. The reassuring physician had replaced the technical master as Dr. Noble's preferred mentor.

Arrowsmith, however, most compellingly explored the reassertion of reassurance as the preferred component to the doctor/patient interaction. Sinclair Lewis compared the smooth, successful reassuring styles of several established physicians to Martin Arrowsmith's botched patient care. Dr. Silva, the Winnemac Medical School dean, "known as 'Dad Silva'...was a round little man with a little crescent of mustache. Silva's god was Sir William Osler, his religion was the art of sympathetic healing, and his patriotism was accurate physical diagnosis"⁴¹⁵. The dean's pleasing manner prompted his patients to call him 'dad'. Dr. Hesselink, the Wheatsylvania family doctor, also centered his practice around reassurance. Comforting Leora during her miscarriage, Martin, "trained to the false cheerfulness of the doctor, he shouted..."There, that's fine, old girl! Wouldn't be making a good baby if you weren't sick. Everybody is."⁴¹⁶. Martin's pretentiously false reassurances were sharply contrasted to Dr. Hesselink's genuine effort, "that gravity and charm, that pity and sureness, which made people entrust their lives to him...an older and wiser brother, very compassionate"⁴¹⁷.

⁴¹⁴Ibid., p.267.

⁴¹⁵Lewis, Arrowsmith, p.83.

⁴¹⁶Ibid., p.173.

⁴¹⁷Ibid., p.174.

Even Dr. Pickerbaugh, Nautilus's public health Director stealthily incorporated reassurance in his preachings. Realizing the daunting challenge of convincing and enforcing his simple public to react to abstract scientific conclusions and change entrenched lifestyle habits, he invoked simple advice glazed with reassurance. He reduced major public health initiatives into palatable, benign poetic offerings:

"Boil the milk bottles or by gum
You better buy your ticket to kingdom come"⁴¹⁸.

Dr. Pickerbaugh glowed in his success. "You'll readily see how one of these efforts of mine, just by having a good laugh and a punch and a melody in it, does gild the pill and make careless folks stop spitting on the sidewalks, and get out into God's great outdoors and get their lungs packed full of ozone and lead a real hairy-chested he-life"⁴¹⁹. His public's testimonials revealed his success. Although "he hollers a good deal,...he's one awful brainy man. He certainly can sling the Queen's English, and jever hear one of his poems? They're darn bright...He's a great old coot"⁴²⁰.

Dr. Arrowsmith did not pursue reassurance and his success as a physician suffered accordingly. In Wheatsylvania, Martin upset the local dairy farmers by blatantly proclaiming their cattle infested with tuberculosis. The farmers reacted vehemently. "Who does he think he is? We call him in for doctoring, not for bossing. Why the damn' fool said we ought to burn down our houses-said we were committing a crime if we had that con. here! Won't stand for nobody

⁴¹⁸ibid., p.196.

⁴¹⁹ibid., p.197.

⁴²⁰ibid., pp.208-209.

talking to me like that!"⁴²¹. Dr. Arrowsmith offered detailed scientific explanations regarding tuberculosis's risks and the best methods for prevention. However, his distinctively authoritarian, nonreassuring tone alienated the farmers, making them loath to his suggestions. Martin's lack of patience also cost him his position in Nautilus. Martin's colleagues already disliked him "not only because of the enlarged [free] clinics, but because he rarely asked their help and never their advice"⁴²². However, he was popular, with supporters including Nautilus's prominent business set. His incapacity for reassuring behavior destroyed this base. He displayed anger and frustration rather than coolly excusing his busy self when his friends would visit his laboratory and interrupted his work. "Opposition to Martin developed all at once...there came from Mayor Pugh a hint that he would save trouble by resigning"⁴²³.

Explanation and intervention, although still highly valued, decreased in desirability. In Arrowsmith, the steel-faced surgeon acquired the image of the masked thief. Roscoe Geake, an otolaryngologist, "believed that tonsils had been placed in the human organism for the purpose of providing the specialists with closed motors. A physician who left the tonsils in any patient was...foully and ignorantly overlooking his future health and comfort-the physician's future health and comfort"⁴²⁴. The Rouncefield surgical clinic harbored similar philosophies. "Any portions of the body without which people could conceivably get along should certainly be removed at once"⁴²⁵. Patients could no longer be

⁴²¹Ibid., p.172.

⁴²²Ibid., p.262.

⁴²³Ibid., p.262.

⁴²⁴Ibid., p.83.

⁴²⁵Ibid., pp.270-271.

sure whether an intervention was truly in their best interests and grew wary of their advocates. Rural practitioners Coughlin and Tromp scoffed at the overuse of specialized interventions. "Hell, scientific! I don't know if its the latest fad and wrinkle in science or not but I get results and that's what I'm looking for's results"⁴²⁶. The 1920's patient opted for simple interventions that guaranteed results over newer ones with dubious quality.

Dr. Nye practiced simple medicine but consistently produced good results. His constant level of unhurried activity crowned him a hero. A flurry of activity characterized Dr. Nye's practice. "The next day, one of the Gonzales twins-first set-came down with the measles. The others followed suit. The Dragona children next door entered in competition. Ephraim Nye, M.D., was in demand, and for the first time since his return was extremely busy with a real, if not lucrative practice"⁴²⁷. Another evening, "his supper was not finished when a messenger from one of the measles-infested household came to tell him of another case in the family and beg him to come at once. He did not return home until almost midnight and the next morning...was obliged to go out again"⁴²⁸.

His smooth but unpretentious interventional style carried Ostable through the onslaught of typhoid. "Upon Dr. Nye fell the weightiest burden of those heavy weeks...Nye commanded as well as served at the front. Daylight and darkness were very much alike to him then. He slept when and where he could and ate or did not eat, just as it happened...Slowly, very slowly, he and his

⁴²⁶Ibid., p.177.

⁴²⁷Lincoln, Dr. Nye, p.151.

⁴²⁸Ibid., p.156.

associates began to get the better of the disease"⁴²⁹. Dr. Parker's ambivalence to decisively join the typhoid foray foiled Dr. Nye's open willingness to act. The typhoid outbreak revealed Dr. Parker's blasé attitude. "I am sorry to hear it, very sorry of course. If it were possible for me to-er-assist you professionally I should do so. But I am busy, very busy, with my own patients. I have not been well lately, and I am tired, very tired. I must not take on more work at present. I am sorry, but I am sure you will understand. Possibly Doctor Hayes-"⁴³⁰. This vacillating response disgusted Dr. Nye. Unflinching dedication and perseverance replaced cold, sharp steel as the preferred avenue for intervention.

David Noble's most gratifying intervention was his vigilant attendance for Jacqueline's internal trauma. Unlike his previous cases tackled with a cool disposition⁴³¹, he attacked Jacqueline's case "with a ferocity that was as primitive as that of a cave-man, fighting for his mate. 'This is the thousandth chance,' he said savagely, 'I'm going to do it, and do it well-and I would if I hadn't anything but a pair of shears and a piece of twine to do it with, too'"⁴³². His passionate involvement continued through the postoperative management. "During that time, he did not have his clothes off, did not go further from Jacqueline's room than the kitchen, and seldom as far as that...He ate his meals in gulps, he slept, when he slept at all, for an hour at a time on a couch just outside her door"⁴³³. The good physician identified with the patient's suffering and directed

⁴²⁹Ibid., pp.288-289.

⁴³⁰Ibid., p.280.

⁴³¹Keyes, David Noble, p.180.

⁴³²Ibid., p.241.

⁴³³Ibid., p.242.

interventions to alleviate the anguish. "He felt he would willingly have been cut in tiny pieces if he could first see her drift off into a painless, dreamless slumber. One night-one hideous, panting, agonized, writhing life-time, that seemed alive with horror and might-revealed more to him about suffering-the way it must be endured, the way it must, if possible, be conquered-than months of complacent practice had done. Ten of them, coming one after the other, without respite, made him marvel that he had ever thought he knew anything about bodily pain or mental anguish"⁴³⁴. David Noble reached this ideal only after experiencing Jacqueline's pain.

Patients, wary and skeptical of any medical intervention, appreciated an explanatory preamble prior to accepting a procedure. Arrowsmith's Dr. Geake reemphasized its important application. "Explain to him, also to his stricken and anxious family, the hard work and thought you are giving to his case, and so to make him feel that the good you have done him..."⁴³⁵. Dr. Arrowsmith's failure to recognize this prerequisite contributed to his medical failure. On call in Wheatsylvania, he injected a sickly girl with diphtheria antitoxin. The patient died within seconds of the injection. The anxious parents were both angry and confused. Unfamiliar with syringes and antitoxin, they pounced on Martin exclaiming "you killed her with that needle thing! And not even tell us so we could call the priest"⁴³⁶. Dr. Arrowsmith's mistake was in omitting an explanation of the procedure. Upon returning with the toxin, he "grunted 'thank God' and angrily called for hot water...Swiftly, smoothly, he made the

⁴³⁴Ibid., pp.242-244.

⁴³⁵Lewis, Arrowsmith, p.84.

⁴³⁶Ibid., p.162.

intravenous injection of the antitoxin and stood expectant"⁴³⁷. He never paused to explain to the parents his intentions, especially important given the antitoxin's newness in rural Wheatsylvania. An explanation may have not only assuaged the parents for their ensuing loss but also averted Dr. Arrowsmith's eventual unravelling in Wheatsylvania.

⁴³⁷Ibid., p.161.

CHAPTER 3: THE PHYSICIAN'S SOURCE OF AUTHORITY

While building their profession, American physicians perceived their biggest struggle to be the establishment of professional authority. Unlike eighteenth century England, where the physician occupied a privileged and elite position in society, American democratic egalitarianism directed that no individual or profession should outrank any other. The practice of colonial American medicine was a domestic institution with its principal responsibilities resting on the family matriarch. Her task was to maintain a stock of medicinal herbs and tend the household ill. The late 1700's featured simple pamphlets distributed to farmhouses cataloguing elixir recipes and quick fixes for common ailments. These publications emphasized that physicians were required only for the most perplexing illnesses, those incurable by standard home techniques. By attending dying patients and consoling the family, physicians were viewed not as great interventionists but as Nature's witnesses⁴³⁸.

Jacksonian Egalitarianism further hampered efforts to establish professional authority. England's Royal College of Physicians, the elite consulting physicians clique, retained their authority by both restricting access to but a few men and rigorously examining potential members. This elite remained in England. Trained American physicians were at best surgeons and apothecaries; at its worst, industrious folk plastering shingles to advertise homestyle remedies. Any individual readily obtained professional access. By the 1830's, medical sectarians, scorning regular medicine's drastic heroics, argued for the unalienable right to practice in accordance with their medical philosophies. Their practices

⁴³⁸Starr, *op. cit.*, pp.32-37.

particularly flourished in rural America. The regular profession, confronted, sought to firmly entrench their professional authority⁴³⁹.

The physician valued authority as an integral ingredient in making a medical career. Considering itself the authentic healer, the regular profession strove to gain its patients' complete trust and confidence. Legally, this was achieved between the 1840's and 1850's through legitimizing professional organization⁴⁴⁰(licensure followed in the 1880's⁴⁴¹). Nonetheless, with the dawn of the 1860's, the physician still accepted that his authority was precarious. Becoming a physician neither implied nor guaranteed socio-economic superiority. Bernard Langdon, although hailing from established New England stock, was the eldest of a large Langdon brood. Consequently, he was both "obliged, from an early period, to support himself and found himself stopped short in his studies by the inability of good people at home to furnish him the present means of support as a student"⁴⁴². Neither were physicians regarded as prestigious husband material. In In War Time, "It had occurred to Mrs. Grace that if things came to the worst a rising doctor might be better for Sarah than no

⁴³⁹Ibid., pp. 37-40.

⁴⁴⁰In 1844, New York State repealed the final piece of legislation protecting the regular physician's practice and initiated a 'laissez-faire' atmosphere within the medical profession. New York's physicians, dissatisfied with the equal status offered sectarians organized into a society. Acceptance into the society would only be extended to members of the medical profession deemed worthy of its honors and fit to perform its duties. In 1847, the New York society met with other state medical societies in an effort to raise the regular profession's authority, forming the American Medical Association (AMA). Nationally, Jacksonian ideals prompted an 'anti-licensing' movement. The medical profession, unable to separate its legitimate practitioners by means of a license, substituted AMA membership in its stead. King, Vignettes IV, pp.1749-1752; Stevens, op. cit., p.29.

⁴⁴¹Starr, op. cit., p.104.

⁴⁴²Holmes, Elsie Venner, pp.15-16.

one"⁴⁴³. Mrs. Westerly "laughed aloud, in a little scornfully defiant way, thinking how her English friends would cry, 'A medical man!' when they learned she had married a country doctor"⁴⁴⁴.

The Civil War affirmed the physician's usefulness⁴⁴⁵. Compared to that of other nationalities, the ante-bellum American physician's social station was comparatively weak. "In all other lands medicine had places of trust and even of power,...but with us, save when some unfortunate physician was abruptly called into public notice by a judicial trial...he lived unnoted by the great public and, for all the larger uses he should have had for the commonwealth, quite unemployed. The war changed the relations of the profession to the state and to the national life, and hardly less remarkably altered its standards of what it should and must demand of itself in the future"⁴⁴⁶. United under the cause of war, diverse groups of physicians created a network for emergent patient care. Ambulances channeled wounded from battlefield aid stations to mobile field hospitals and ultimately to the general hospital. Triage and trauma management occurred in each institution⁴⁴⁷. Erecting sprawling general hospitals⁴⁴⁸, however,

⁴⁴³Mitchell, In War Time, p.139.

⁴⁴⁴Ibid., p.142.

⁴⁴⁵The first major Civil War battle at Bull Run was a medical disaster. The retreating Union army lost 681 men and wounded 1011. Care for the wounded was nonexistent. There was no organized system to remove the wounded from the battlefield and no facility to tend those rescued. The wounded staggered down local streets seeking aid. Three years later at the battle of Spottsylvania, the situation was radically different. An established Army Corps and efficient hospital greeted the 7000 Union casualties. The new, clean hospitals and their attending surgeons won the respect of not only thousands of wounded soldiers but also of a torn and confused nation. William F. Blaisdell, "Medical Advances During the Civil War", *Archives of Surgery*, vol. 23 (1988), pp.1045-1050.

⁴⁴⁶Mitchell, In War Time, p.25.

⁴⁴⁷Blaisdell, op. cit., pp.1045-1050.

⁴⁴⁸By 1863, the Union had constructed 151 hospitals with capacity of 58,715 beds. The number more than doubled two years later. The hospitals, emphasizing cleanliness, were organized in

strongly augmented the physician's professional authority. "Vast hospitals were planned and admirably built, without the advice of architects, by physicians...The hospitals numbered twenty-five thousand beds for the sick and wounded; and these huge villages, now drawn on by the war, now refilled by its constant strife, were managed with a skill which justified the American test of hotel-keeping as a gauge of ability"⁴⁴⁹. Of the physicians recruited to attend these behemoths, "a surgeon taken abruptly from civil life, a country physician, a retired naval surgeon, were fair specimens of the class on which fell these enormous responsibilities. We may well look back with gratification and wonder at the exactness, the discipline, the comfort, which reigned in most of these vast institutions"⁴⁵⁰.

The Civil War's repercussions were significant⁴⁵¹, irrefutably augmenting the physician's authority and respectability. The physician no longer ranked among the lowest professional castes. In Doctor Sevier, Kate Ristofalo dreamed for her son Mike to establish a prestigious calling. "His mother had changed her mind about his being a bruiser, though there isn't a doubt that he had a

pavilions, each interconnected by a system of corridors. Each barrack, to maximize patient comfort and minimize contagion, possessed high ceilings, open ventilation and amply spaced beds. Successful, these hospitals served as models for civilian hospitals for the next seventy-five years. Ibid., pp.1045-1050.

⁴⁴⁹Mitchell, In War Time, p.25.

⁴⁵⁰Ibid., pp.25-26.

⁴⁵¹The high patient volume during the Civil War precipitated significant medical advances. Extremity wounds were most common and amputations frequently required. Surgeons established the need for immediate, definitive treatment of wounds and fractures-treatment within the first twenty-four hours following injury resulted in optimal healing. With respect to bullet wounds, surgeons developed novel instruments for both assessing wound severity and extracting bullets and damaged tissue. Hygiene and sanitation were recognized as important preventative measures in halting the spread of infectious epidemics. Finally, participation in Wartime medicine offered thousands of American physicians 'postgraduate training' with particular attention to proper anaesthetic usage, surgical technique and management of infectious diseases and increased the overall standard of American medical care. Blaisdell, op. cit., pp.1045-1050.

Derringer in one or another of his pockets. No, she was proposing to make him a doctor-'a surgeon...and thin, if there bees another war'-she was for making every edge cut"⁴⁵². Marrying a doctor attained new respectability. "'Austin [Dr. Sloper] married a wife with money...' 'Ah! but your brother was a doctor'"⁴⁵³.

Nonetheless, the expansion of investigational science and its clinical applications provided the ammunition the regular medical profession yearned for. Up through the 1860's, the liberally educated laity provided the strongest opposition to organized medicine. Arguing that freedom of knowledge was integral to the American people, they challenged the medical profession's authority to restrict entry to the profession. They viewed medical licensure and society organization as monopolistic ploys by a socially unflinching elite; if the knowledge was procurable then it should be accessible to any interested American, licensed or not⁴⁵⁴. Basic science's incorporation into the medical curriculum destroyed this argument. Scientific theory could only be studied in medical schools. The regular physician acquired diagnostic and technical skills unobtainable elsewhere. Society regarded the physician, now armed with a unique and powerful knowledge base, with awe, respect and trust. The regular profession had established a legitimate and recognized position in American society.

Entering the Gilded Age, the profession faced the novel challenge of internal consensus⁴⁵⁵. Dr. Wendell, "while respected as a man with much

⁴⁵²Cable, Dr. Sevier, p.471.

⁴⁵³James, Washington Square, p.85.

⁴⁵⁴Starr, op. cit., p.57.

⁴⁵⁵Ibid., p.81.

general and scientific knowledge, he was known among doctors as having contributed nothing to their journals save barren reports of cases...But of these siftings of a man by his fellows, the public which is to use him learns little or nothing, so that to Alice Westerly he represented the brilliant and original physician to be justified by the patient issues of the years..."⁴⁵⁶. Unbeknownst to the serviced public, the struggle for authority shifted internally. Regular physicians jockeyed amongst themselves for professional supremacy.

Specifically, the rise of specialism threatened the general practitioner's authority⁴⁵⁷. Dr. Kittredge's description reflected the generalist's 1860's authority. "Ah, yes. The Country Doctor-half a dollar a visit-drive, drive all day-get up at night and harness your horse-drive again ten miles in a snowstorm-shake powders out of two phials-drive back again, if you don't happen to get stuck in a drift-no home, no peace, no continuous meals, no unbroken sleep, no Sunday, no holiday, no social intercourse"⁴⁵⁸. Dr. Kittredge's authority stemmed from this gruelling schedule. "He kept three or four horses...commonly driving in a sulky, pretty fast, looking straight ahead before him so that people got out of the way of bowing to him as he passed on the road"⁴⁵⁹.

⁴⁵⁶Mitchell, In War Time, p.113.

⁴⁵⁷The specialists' clamor to restrict most procedures to adequately trained practitioners threatened the generalist. The whittling away at his self-image of competence demoralized the generalist physician. The generalist attempted to adopt a new image of family psychosocial consultant with particular attention to purely 'medical' issues. They would freely refer out complex cases. However, in the patient's own desire for optimal medical care, they often directly consulted a specialist without the generalist's referral. Generalists, losing their professional authority (and a substantial income source), struggled to reestablish their professional position. Ultimately, generalists aspired for a channelled system which, like Britain's, required a generalist's referral to access specialty practices. Stevens, op. cit., pp. 80-82.

⁴⁵⁸Holmes, Elsie Venner, pp.20-21.

⁴⁵⁹Ibid., p.98.

In 1910, The Healer's Mrs. Goodnow highlighted the gaping stratification between the city specialist and the country generalist. Following Nell's subdural hemorrhage, "Mrs. Goodnow exclaimed scornfully, '...No, I should have taken her away or sent for someone from the city. Dr. Jenks would have come-and been here by this time'"⁴⁶⁰. She reacted similarly to Dr. Holden's initial prognosis. "I won't believe it-until somebody besides a country doctor tells me it is so"⁴⁶¹. Mrs. Goodnow disqualified Dr. Holden's competency due to his generalist's affiliation. In Arrowsmith, Wheatsylvania generalists Coughlin and Tromp expressed their frustrations towards their perceived professional impotence. "I tell you, a plug G.P. may not have a lot of letters after his name, but he sees a slew of mysterious things that he can't explain, and I swear I believe most of these damn' alleged scientists could learn a whale of a lot from the plain country practitioners, let me tell you"⁴⁶². The generalist's struggle to regain its sense of legitimacy continues through the present day⁴⁶³.

I. What Characteristics Made A Physician Authoritative

⁴⁶⁰Herrick, Healer, p.5.

⁴⁶¹Ibid., p.13.

⁴⁶²Lewis, Arrowsmith, p.177.

⁴⁶³January 1993, I personally received from John M. Tudor Jr., President of the American Academy of Family Physicians. The letter attempted to justify family practice as a 'legitimate' medical career option. It stated "I am writing to you today to make sure you are aware of the wealth of information available about family practice...Now, more than ever, every medical student would be wise to consider his or her potential to become a family physician...Family physicians are in great demand across the country...you do have a right to more information about this exciting, challenging and greatly needed *specialty*" (italics mine). Personal Letter from John M. Tudor, Jr., President of the American Academy of Family Physicians, to Bonnie E. Gould, Third Year Medical Student, January, 1993.

In the late nineteenth- and early twentieth-centuries, the regular medical profession struggled for its position of authority. Nonetheless, the individual physician acquired a highly esteemed place in the nonmedical world's eyes. The physician's unique responsibility for patient care poised him above economic status, politics, family ties and other standard social conventions and coined him "indisputably usefulest of all mankind"⁴⁶⁴. Yet, this usefulness must have stemmed from assuming a more involved role than witnessing human natural history.

In considering professional authority, specific characteristics were associated with the good physician's practice. These characteristics can be divided into two broad categories: those directly related to his professional activities (professional authority) and those connected with his human social values (integrity of character). Although the profession's basis for authority fluctuated between 1859 and 1925, the individual physician's requisite catalogue of traits remained remarkably stable throughout this period. Despite the heralding developments in medical science and practice, the patient still demanded of and exalted his physician for an unflinchingly specific subset of traits and mannerisms. These influenced the good physician's power of authority.

A. Professional Authority

Professional authority invoked the physician's ability to command authority in the sick-room. It included cataloguing those traits and mannerisms which affected the patient's confidence and trust in his/her physician's clinical acumen⁴⁶⁵. Acquiring professional authority was essential to the profession's

⁴⁶⁴Wilbanks, Doctor as Romantic Hero, pp.54-57.

⁴⁶⁵Eric J. Cassell described this concept of professional authority in the opening paragraphs of his paper. Cassell, Changing Concept Ideal Physician, pp.185-186.

integrity. The physician's professional integrity depended upon garnering this authority; it offered him his patients' undivided attention and confidence. Four key elements contributing to the physician's professional authority were to preside over life and death, to demonstrate confidence and bravery, to assume responsibility for one's decisions, and, simply, to be a physician.

i. The Title 'Doctor'

In each novel, simply by being a physician the doctor commanded authority in both patient care and social contact. Dr. Kittredge's sole merit for earning an invitation to Widow Rowens's dinner party was that "the old doctor-he's always handy"⁴⁶⁶. A respected man would always fit in with any prominent dinner crowd. Moreover, she felt that Dr. Kittredge's professional authority would be a reasonable social buffer for the party. "She wanted the Doctor, particularly. It was odd, but she was afraid of Elsie. She felt as if she would be safe enough, if the old Doctor were there to see to the girl"⁴⁶⁷. Similarly, Dr. Rast's invitation to the organ grinder's golden wedding anniversary resulted "because we asked the Rabbi and he said he was busy...there is Dr. Rast-we all love him"⁴⁶⁸.

Bearing the title 'physician' also permitted the doctor to influence areas of society not necessarily related to the medical trade. Dr. Sevier's letter of recommendation obtained John Richling his first solid employment. Despite the fact that the Doctor never employed Richling himself his testimonial to

⁴⁶⁶Holmes, Elsie Venner, p.291.

⁴⁶⁷Ibid., p.293.

⁴⁶⁸Oppenheim, Doctor Rast, p.75.

Richling's character positively impressed potential employers. Richling requested Dr. Sevier to supply a letter of reference to Reisen, the baker. "The Doctor turned to his desk and wrote...not many days after,...'Dear Doctor, I've got the place'"⁴⁶⁹. Davis had Dr. DuBois assume, of his own accord, curatorship over Captain Aragoni's suicide note and estate papers and held them from the widowed Sofia. "Not deeming her mind sufficiently restored to receive them, he cautiously locked them up in his own house with other papers of value"⁴⁷⁰. Acknowledgment of DuBois's professional authority permitted him to proceed independently without invoking legal counsel.

Most importantly, invoking one's physicianhood often allowed the doctor to intervene at emergencies without the interference of the bystanding public. Dr. Boynton, on his way to a meeting, "was delayed by an accident: a child was run over in the street almost before my eyes, and was carried into the next apothecary's. The force of habit is strong; I remembered that I was a physician, and forgot the larger in the lesser duty, till other attendance could be procured"⁴⁷¹.

Dr. Nye, banished from the Copeland clan, jumped with alacrity to rescue Faith Copeland following her car accident. Prior to Dr. Parker's arrival, Dr. Nye won respect as the interim caretaker. Having sent for Dr. Parker, he tended Faith's injuries-"she regained consciousness about six o'clock and was inclined to be excited and apprehensive. I gave her a quieting dose. Nothing drastic. You [Dr. Parker] saw it on the chart, of course, and no doubt Miss Dana told you"⁴⁷².

⁴⁶⁹Cable, Dr. Sevier, pp.249-250.

⁴⁷⁰Davis, Tale of a Physician, p.47.

⁴⁷¹Howells, Undiscovered Country, pp.90-91.

⁴⁷²Lincoln, Dr. Nye, p.125.

Even after Dr. Parker's assumption of the case, Dr. Nye persisted to exercise authority over the case. He questioned the inopportunity of Dr. Parker's plan of relocating the injured party in a more respectable lodging. "I am putting it as plainly as I can. Do you suggest that she be taken to her own home at once? Will you assume the responsibility for having her taken there-now?...I most emphatically refuse to take it. If she is moved tonight-or tomorrow-yes, or within a fortnight, I shall have nothing whatever to do with it. Plainly, I think it might kill her, and I won't be a party to murder"⁴⁷³.

David Noble, by invoking his physician-ness, orchestrated Jacqueline's resuscitation following her traumatic accident. He carried Jacqueline into the cottage house and started: "I am a doctor. I know what to do. Help me all you can. It's going to be all right. And later I'll explain. Now every minute we waste may mean this lady's life. Bring me some cold water-have you any ice in the house?...Find some one to send for your village doctor, *quick!* Tell him to bring morphia, ether or chloroform too if he has it, but surely morphia...and all the instruments he has-*hurry!*"⁴⁷⁴. All of Dr. Noble's requests were promptly filled.

Martin Arrowsmith attempted to capture the authority of physician-ness when, as a medical student, he entered Zenith General Hospital to acquire some lab specimens. "Through the long hallways...Martin wandered, trying to look important, hoping to be taken for a doctor...He passed several nurses rapidly, half nodding to them, in the manner (or what he conceived to be the manner) of a brilliant surgeon who is about to operate"⁴⁷⁵. Martin actually savored this

⁴⁷³Ibid., p.127.

⁴⁷⁴Keyes, David Noble, p.224.

⁴⁷⁵Lewis, Arrowsmith, p.53.

authority as an intern attending the ambulance. "At the back, haughty in white uniform, nonchalant on a narrow seat, was The Doctor-Martin Arrowsmith. The crowd admired him, the policeman sprang to receive him...He owned the city, he and the driver..."⁴⁷⁶.

ii. **Presidence over Life and Death**

The nineteenth- and early twentieth-century physician derived his professional authority in part due to his relation to power over life and death⁴⁷⁷. As Weir Mitchell aptly interposed, "There probably is no physician who cannot recall some moment in his life when he looked with doubt and trouble of mind on the face of death; but for the most part, his is a profession carried on with uprightedness and habitual usefulness"⁴⁷⁸. Dr. Bryson was more direct. "Did you [Mrs. Eliot] ever see anybody die? Never do it if you can help it. Keep away from deathbeds as long as you can. A child's death isn't pleasant; a woman's is worse; a man's is horrible"⁴⁷⁹. Dr. Bryson hoarded Johnnie Ledgcott's death. "Don't stay here, don't see him die. That's for me to do; it is my reward"⁴⁸⁰.

It was said of Dr. Kittredge that "he looks at a man and says he is going to die"⁴⁸¹.

⁴⁷⁶Ibid., pp.117-118.

⁴⁷⁷Wilbanks, op. cit., pp.54-57.

⁴⁷⁸Mitchell, In War Time, p.10.

⁴⁷⁹Spearman, Doctor Bryson, p.105.

⁴⁸⁰Ibid., p.106.

⁴⁸¹Holmes, Elsie Venner, p.178.

Martin Arrowsmith's authority while riding the ambulance was specifically due to his being the first one to divine a victim's prognosis. "A lieutenant of firemen led him to a pile of sawdust on which was huddled an unconscious youngster, his face bloodless and clammy. 'He got a bad dose of smoke from the green lumber and keeled over. Fine kid. Is he a goner?', the lieutenant begged. Martin knelt by the man, felt his pulse, listened to his breathing. Brusquely opening a black bag, he gave him a hypodermic of strychnin and held a vial of ammonia to his nose. 'He'll come around. Here, you two, getum into the ambulance-hustle!' The police sargeant and the newest probation patrolman sprang together and together they mumbled 'all right doc'"⁴⁸².

Dr. Nye triumphantly managed the typhoid treatment team and prevented many otherwise imminent deaths. Dr. Nye repeated his heroics, curing Tom Stone from a virulent pneumonia. The Ostable community, previously doubtful of Dr. Nye's clinical worth, felt secure in his achievements. For his work at manipulating human fate, "they are calling you... 'the miracle man'. That was the name of a play a few years ago. It's hero saved people's lives, just as you have been doing"⁴⁸³. Ultimately, his power over life and death restored his authority within a skeptical community.

Because of their willingness to fearlessly confront St. Huberts's bubonic plague death threat, Drs. Stokes of St. Swithins, Oliver Marchand, Ira Hinckley, and Gustaf Sondelius commanded the authority over the appointed Surgeon General, Dr. R.E. Inchcape Jones. Dr. Stokes, a "reticent man, and hard", courageously offered Dr. Arrowsmith his parish for phage experiments should it

⁴⁸²Lewis, Arrowsmith, pp.117-118.

⁴⁸³Lincoln, Dr. Nye, p.333.

become necessary⁴⁸⁴. Dr. Sondelius, particularly roused at the prospect of rat-killing, "rumbled in...in an impassioned silk dressing gown...if ever, spectacled and stooped, he had looked old, he was young and boisterous"⁴⁸⁵. He engaged rat-killing as a passion. Jurisdiction his power to control life and death, he "arbitrarily dragged bookkeepers and porters from their work, to pursue the rats...He made a violent red and green rat map of the town. He broke every law of property"⁴⁸⁶. Ira had "nursed the poor plague-stricken devils"⁴⁸⁷. Dr. Sondelius's death reflected the nobility inherent in their confrontation with death. Stricken, he staggered through, acknowledged his flea bite and died of heart failure coincident with delirium several days afterward⁴⁸⁸. Contrastingly, Dr. R.E. Inchcape Jones, "lean but apple-cheeked, worried and hasty"⁴⁸⁹, from the outset had "lost his head. Running in circles, lancing buboes-afraid to burn Carib, where most of the infection is"⁴⁹⁰. Haunted by death and dying, he, in staccato speech, referred to disease with a devilish spectre. "Schoolhouse. Turned it into a pesthouse. Hundred cases in there. Die every hour. Have to guard it-patients get delirious and try to escape"⁴⁹¹. Unlike the others he could not face death with a knowing authority. Having furtively escaped the island under the cover of night,

⁴⁸⁴Lewis, Arrowsmith, pp.364-365.

⁴⁸⁵Ibid., p.365.

⁴⁸⁶Ibid., p.372.

⁴⁸⁷Ibid., p.367.

⁴⁸⁸Ibid., pp.380-381.

⁴⁸⁹Ibid., p.366.

⁴⁹⁰Ibid., p.364.

⁴⁹¹Ibid., p.368.

he died the death of a coward. "With the revolver which he had carried to drive terrified patients back into isolation wards...he killed himself"⁴⁹².

The physician's commanding presence over human mortality conferred upon him an element of immortality. Speculating upon contents of Dr. Sloper's will, Washington Square's Mrs. Penniman needed to convince herself that "even doctors must die"⁴⁹³.

As testament to his guardianship over life and death, the physician desired patient compliance with his recommendations. Dr. Sloper exerted this power over his daughter when he initially forbade her to date Morris. As if prescribing an acrid remedy noted for producing protests and fitful expressions, he postscripted his admonition with "I have told you what I think. If you choose to see him, you will be an ungrateful, cruel child"⁴⁹⁴. He then remained by the closed front door, following his successes. "He was sorry for her...but he was so sure he was right...The doctor took several turns round his study...'By Jove, I believe she will stick'...He determined to see it out."⁴⁹⁵.

Dr. Kittredge's face was permanently warped into an authoritarian presence. Compared to the mealy Reverend, "his face looked tough and weather-worn...The Doctor's was the grimmer of the two; there was something of grimness about it, -partly owing to...the long companionship with that stern personage who never deals in sentiment or pleasantry. His speech was apt to be brief and peremptory; it was a way he got by ordering patients"⁴⁹⁶.

⁴⁹²ibid., p.383.

⁴⁹³James, Washington Square, p.85.

⁴⁹⁴ibid., p.96.

⁴⁹⁵ibid., p.96.

⁴⁹⁶Holmes, Elsie Venner, p.314.

Jane Grabo progressed throughout most of her adolescence resenting the Lower East Side tenement squalor and poverty. Daily, she shuddered on the trolley-ride home which would return her to back to the dreaded neighborhood. When Dr. Rast exclaimed that through her insolence and complete disregard for family, she had killed her sister, "she cried out: 'No, no! I haven't killed her, not I'. But Dr. Rast had said it, and he never lied"⁴⁹⁷. Furthermore, upon hearing the diagnosis, Jane vowed to change. "She, herself would nurse the child-would warm it back to life; she would earn money too-study short hand at night-anything-and Esther and Beth should be wrenched loose. She would change all. It would not be too late"⁴⁹⁸. Presiding over life and death, Dr. Rast's diagnostic and therapeutic authority was complete. All he said was accepted as truth, and his prescriptions adhered to.

iii. Accountability

A third element in a physician's professional authority was accountability. A physician was required to assume full responsibility for his entire spectrum of actions irrespective of their outcome. This ideal was related, in part, to the prevalence of malpractice litigation, dating from the 1840's as an established American crusade against the regular practitioner⁴⁹⁹. Faced with the constant

⁴⁹⁷Oppenheim, Doctor Rast, p.57.

⁴⁹⁸Ibid., p.57.

⁴⁹⁹By 1840's came to afflict regular practice as well. Most 1840's and 50's malpractice was directed against unforeseen side effects of new technologies. A classic example describes a suit based on acquiring a shortened limb following the setting of a compound fracture. What the suit omitted was the fact that prior to devising a method to set and heal these fractures, standard of care dictated limb amputation-not only would the patient not have had a case, but he also would have been short a limb! By the 1850's, the 'standard of care' argument was enhanced so that physicians were equally being sued for what they did not do as well. With the popularization of malpractice litigation, the medical community began to realize that the most frequently chastised physicians were those with more prominent reputations, the ones most apt to have sufficient funds

threat of litigation, even many years after performance of the questioned procedure⁵⁰⁰, physicians experienced pressure from both patients and colleagues to stand by one's decisions, no matter the consequences. The good physician never shirked his responsibilities. Keyes supported this ideal. "Sick people...are such awful fools. They'd rather be ignorantly murdered by someone who really feels sorry for them and speaks to 'em kindly, then saved by a living miracle of dexterity and daring who regards 'em in the same light as he does his motor-thrilling machinery, that's all"⁵⁰¹.

Dr. DuBois was initially frightened when, during his first professional encounter with Sofia, she completely and profoundly responded to his application of hypnosis. Worried that "he had, possibly, by some malapplication of the mysterious mesmeric power, superinduced a state of delirium. Perhaps (oh, horrible!) he had induced insanity,...The first thing the doctor resolved upon was, to make a few more manipulations in the air over the reclining and now sleeping patient...to impart to her nerves somewhat of his own superabundance of health and vital spirits"⁵⁰². His sense of responsibility could not allow the possibility of something going awry without effecting an intervention.

to pay out a reasonable settlement payment. Distraught by apparent plaintiff successes, they sought to establish a 'physician court' where they could be tried by their peers (like the clergy or the armed forces) and integrated medical jurisprudence concepts into medical school curricula. James C. Mohr, "The Emergence of Medical Malpractice in America", *Transactions and Studies of the College of Physicians of Philadelphia*, vol. 14 (1992), pp.1-21.

⁵⁰⁰Labelled 'illegal fishing expeditions', one of the more common methods to seek out probable case material was to search in a patient's past for possible instances of neglect and bring these to a court of law. Physicians were being successfully tried against, with plaintiffs receiving large settlements for alleged suffering that only began years after the medical intervention. *Ibid.*, pp.1-21.

⁵⁰¹Keyes, *David Noble*, p.179.

⁵⁰²Davis, *Tale of a Physician*, pp.37-38.

Dr. Lagrange tried to emphasize this point to In War Time's Dr. Wendell. When Mrs. Morton confronted both physicians demanding her husband's prognosis, Dr. Lagrange, "who was precise in all the little matters of the rights and functions of the attending physician"⁵⁰³ did his best to defer this question to the responsible physician, Dr. Wendell. As prescribing physician, Dr. Wendell needed to account for all events in his patient's course, good or bad. Dr. Wendell, "not sorry to shift an unpleasant burden"⁵⁰⁴, missed the cue. This failing was even more apparent in his actions following his accidental poisoning of Edward Morton. Upon tasting the poisoned spoon, "he let it fall, with a shock of remembrance at his own responsibility for what had occurred...Wendell had recognized the taste for the deadly poison and was trying to collect his routed faculties...Wendell saw his own peril. 'Hush Arty, here is the bottle. Look it is all right. No one is to blame'"⁵⁰⁵. Dr. Wendell ignored "how black the lie for self-protection had really been"⁵⁰⁶. Fearful of untoward repercussions to both his financial status and probable betrothal to Mrs. Westerly, he eschewed his professional responsibilities. Ironically, contrary to his motivations, this act forsook any authority he had claimed in the community and precipitated his premature departure.

Keyes's foil between David Noble's and Bobby Hutchinson's practices reflected the importance of accountability. Dr. Noble was a technical master in the operating room. Dr. Hutchinson described himself as "not a surgeon or

⁵⁰³Mitchell, In War Time, p.47.

⁵⁰⁴Ibid., p.47.

⁵⁰⁵Ibid., pp.213-214.

⁵⁰⁶Ibid., p. 215.

specialist, or a-what you call 'em-diagno-I can never get the whole of that word. I'm a general practitioner-obsolete as hoop skirts and stove-pipe hats"⁵⁰⁷. However, where Dr. Hutchinson succeeded; "your patients love you, Bobby", David Noble did not⁵⁰⁸. While Dr. Noble "does slip up on his aftercare", all of Dr. Hutchinson's patients "seem to get well"⁵⁰⁹. Bobby, who diligently followed his patients until their complete convalescence had received the ultimate authority, trusting and appreciative patients. David, who eschewed this responsibility, could not boast of equally satisfying patient encounters. It was further said of Dr. Noble that "if he could only make a huge one [mistake]-medically or otherwise, or both together-and have to go through a perfect hell of grief and contrition and despair and shame-well, then you'd see him come out-if he could come out at all-the greatest physician of his generation"⁵¹⁰, fully appreciating the need for responsible care. David's opportunity arose during his vigil over the injured Jacqueline. "Like most doctors...he had seldom watched beside a patient throughout the night...he went peacefully home to bed. He wondered now how he had ever done it"⁵¹¹. He previously joked how Bobby 'medically babied' his patients⁵¹². Now he recognized the absolute need for accountability and responsible care.

⁵⁰⁷Keyes, David Noble, p.177.

⁵⁰⁸Ibid., p.178.

⁵⁰⁹Ibid., pp.178-179.

⁵¹⁰Ibid., pp.180-181.

⁵¹¹Ibid., p.243.

⁵¹²Ibid., p.244.

Dr. Nye expressed his accountability ideal by accepting the responsibility for the health care needs of a previously neglected community. The Ostable 'Portygee' community acquired the reputation of deadbeats: "Why, Doctor, they'll steal the shirt off your back. They owe everybody in town, and every bill is two years past due"⁵¹³. Not all Ostable physicians adopted this position. "They only sent for you [Dr. Nye] 'cause Doctor Parker won't go there no more unless he gets some money"⁵¹⁴. Dr. Nye, nonetheless, built his practice among the Portuguese clientele. He was "summoned during the next month to five different families. Two of these families paid in cash for each visit and seemed to take pride in so doing. The preponderance of weight was still on the nonpaying side but the doctor made no distinction. He was as solicitous with the Mrs. Joe Gonzales's twins-the second set-as with old Peter Dragona's rheumatism. And, pay or no pay, he was thoroughly enjoying these opportunities to practice his always beloved profession"⁵¹⁵.

Dr. Bryson was even more extreme in assumption of responsibility, particularly in pediatrics. While he felt honored to care for the children of concerned parents, he demanded that parents take an active role in their children's convalescence. He was moved by Mrs. Eliot's concern and devotion. He only charged her fifty dollars, a fraction of the actual cost⁵¹⁶. However, he was merciless with Mrs. Ledgcott. Her son fell morbidly ill while she was out of town, yet she failed to acknowledge any of the emergent telegrams and refused to come

⁵¹³Lincoln, Dr. Nye, p.82.

⁵¹⁴ibid., p.83.

⁵¹⁵ibid., p.84.

⁵¹⁶Spearman, Doctor Bryson, p.73.

home. With the child on his deathbed, "'A woman that will neglect a child like that', he exclaimed in rage, 'ought to be quartered and hung to the four winds'"⁵¹⁷.

iv. Personality Elements: Bravery and Self-Confidence

Distinct from those traits inextricably linked to the physician's professional responsibilities were those attributes of character and personality which influenced his public's opinions. Among the multitudes of potential personality traits, the novels focused on two portrayed as indispensable: bravery/self-sacrifice and self-confidence.

In War Time's Germantown ladies' gossip circle held one of their meetings to discuss the important contributions of bravery and self-sacrifice towards a physician's success. Miss Clemson, the insightful spinster, offered the point of view. "Still, I think it is a brave thing to face disease as they do. I call a man brave who just coolly goes as an everyday affair and takes these risks"⁵¹⁸. Other gossip produced additional ideals. "'But what noble work, and what a life of constant self-sacrifice!'...'I think it to be counted a privilege when one is called to a life of much giving, even of what one is obliged to give"⁵¹⁹. Dr. Wendell was able to win praises for demonstrating these qualities in his practice. "He went last week to see my farmer's wife and she and three of her children had smallpox; and I can tell you if I were a doctor I certainly would not attend cases of smallpox! I did hear that Dr. Withers would not go"⁵²⁰.

⁵¹⁷Ibid., p.104.

⁵¹⁸Mitchell, In War Time, pp.185-186.

⁵¹⁹Ibid., p.113.

⁵²⁰Ibid., p.185.

Dr. Rast's efforts in his Lower East Side practice were painted as a lifetime crusade of self-sacrifice and heroic bravery. Offered a practice in idyllic Hartley, Connecticut, Dr. Rast had a choice. His familiar Lower East Side possessed "the nauseous crowds, the dirty streets, the stinking tenements, the grind...this clamor and rush and excitement drain a man of his very soul...these incessant calls, these bad hours, these money troubles, this overwork"⁵²¹. Comparatively, the affluent rural Connecticut suburb enticed with "a fortune fell into...lap...sit at home and wait till people got sick...It didn't matter whether he [the Doctor] killed people or cured them-he was a Trust...there isn't competition...what country life means-how glorious, sane, sweet, complete it is!"⁵²². At the crucial decision point, Dr. Rast could not leave his flock of dependent immigrants; "he had come down to the East Side to serve his people not only with knife and phial, and strength and time, but also with compassion and understanding. He was a loved brother known in a thousand tenements"⁵²³.

Dr. Rast, drunk with the victory of a difficult birth, realized the nobility of his bravery and self-sacrifice. "It was war, but a new kind-glorious...I saved one child's life...This state of things down here is a great Battle, isn't it?...and I am a trained soldier-I'm fitted to fight-I know these people-I understand all-and-they love me, they love me!"⁵²⁴. "I hunt for germs in dusty places. I hunt for hate in dusty hearts. I lend a little lift here-I touch and heal a body there...possibly...I

⁵²¹Oppenheim, Doctor Rast, pp.18-19.

⁵²²Ibid., p.20.

⁵²³Ibid., p.279.

⁵²⁴Ibid., pp.27-28.

touch a human soul and make it whole!"⁵²⁵. His patients' love and respect reflected their regard for Dr. Rast's bravery and dedication. As for the delivered mother, "her only real joy was Dr. Rast. He was the one human being who was human with her-who encouraged her, who held her up, who sometimes put his hand in his pocket to pay the grocer's bill, who was always to be had when the need came"⁵²⁶.

Dr. Andrew Hecht, the basic scientist, demonstrated the respect and authority gained through bravery and self-sacrifice. Having isolated an immune factor supposed to inhibit the spread of typhoid in rodents, he required a 'Patient #1', the first human to test the serum's therapeutic value and toxicity threshold. For this task, he offered the ultimate sacrifice: he selected himself. Even Dr. Rast, overcome by emotion and respect, could not speak; "somehow tears sprang to his eyes and he swallowed hard. Many men for Science, the Savior, have given up their lives- these lonely disciples...they have gone secretly and alone in quiet"⁵²⁷. The serum failed and Dr. Hecht plummeted towards a deadly case of typhoid. Following his miraculous recovery, his undaunted spirit could only add "do you mind, if later, after I've done some more work, *I try again?*"⁵²⁸.

Complementary to bravery, confidence was similarly valued and equally required within the fabric of the good physician. In displaying one's self-confidence as collateral for one's career, the ultimate reward was reflected in Holmes's description of Bernard Langdon's professor: "to stand at the very top of

⁵²⁵ibid., p.293.

⁵²⁶ibid., p.24.

⁵²⁷ibid., p.186.

⁵²⁸ibid., p.216.

your calling in a great city is something in itself,...a sense of power, limited, it may be, but absolute in its range, so that all the Caesars and Napoleons would have to stand aside, if they came between you and the exercise of your special vocation"⁵²⁹.

Dr. Bryson's calm operating room demeanor was a prime example of the level of self-confidence that was pre- and co-requisite to attaining professional excellence. "Bryson bent over the operating table and looked intently at Ruth...he made no comment, but silent and intent motioned the nurse to turn Ruth's head...'a knife, please'...'tissue forceps, please',...in the low, even tones. 'Tissue forceps', again, and after a time, 'the retractors; not those-the small ones...imperatively quick words in the same steady voice, 'hotter, hotter, nurse, hotter'"⁵³⁰. Despite some nursing errors, Dr. Bryson retained his composure, assured by his confidence. Contrastingly, Angus Duer could not be bothered with these pleasantries. "Dr. Duer would not fail to [be]...appallingly unpleasant to any nurse who made a mistake or looked for a smile"⁵³¹. Dr. Duer demonstrated his inferiority complex through his necessity to chastise his underlings. Lacking Dr. Bryson's congeniality, Dr. Duer mirrored Dr. Noble by being purely motivated to advance his career-his method for augmenting self-esteem. "He never read anything or said anything which would not contribute to his progress as a Brilliant Young Surgeon"⁵³².

⁵²⁹Holmes, Elsie Venner, p.20.

⁵³⁰Spearman, Doctor Bryson, p.64.

⁵³¹Lewis, Arrowsmith, p.270.

⁵³²ibid., p.270.

Dr. Wendell displayed his lack of self-confidence through his inability to tolerate any constructive criticism. "Like most men who think over-well of themselves, he was sensitive to all reproof" and this fault "had unfitted him for the precision which that army surgeon exacted alike from his junior surgeons and his clocks"⁵³³.

Dr. Holden acknowledged that his loss of self-confidence hampered his powers as Healer. "He was spreading himself thinly over a larger surface of effort, was applying himself to each problem with less undivided interest and energy. He knew it...As he gave less of himself to the sick, he perforce had given more medicine,-had fallen back on what he once would have called the chicanery of the profession...all the devices that produce quick spectacular results, that keep the confidence of the sick in the physician. So he was silent, thoughtful,-glum...altogether the harmony, the high atmosphere of peace that was supposed to rest upon the Healing Spring, had been thoroughly disturbed..."⁵³⁴. Eva Smith, a hopeful patient, recaptured the magic exuded by his self-confidence. She countered Dr. Holden's exasperated challenge of "would you throw away the knowledge of two thousand years and all that men are doing today, and depend on one man?" with "if he were a Healer"⁵³⁵. The authority of the authentic Healer transcended the cumulative power of two thousand years of mankind.

However, the most compelling proof for the necessity of confidence was following Dr. Percy Farrold's maturation from young intern to well-respected rural practitioner. Dr. Percy is introduced as "a nice young doctor...fresh from his

⁵³³Mitchell, In War Time, p.4.

⁵³⁴Herrick, Healer, pp.292-294.

⁵³⁵Ibid., p.326.

medical course, and paying his board [at the vacation resort] by looking after possible invalids"⁵³⁶. While able to nurse aging rheumatics, Dr. Percy lacked the confidence to treat a more serious problem. Upon presenting the history of Nell's head injury, "'She seemed all right at first.' 'How long has she been like this?' the other one [Dr. Holden] demanded roughly, as if in accusation. 'Not more than a day-well-the symptoms were misleading', the young man stammered...'After the first shock, there were no symptoms,-no definite symptoms', he corrected himself...He stammered on, using the word 'symptoms' again and again, until the other man shrugged his shoulders contemptuously"⁵³⁷. Dr. Percy's lack of self-confidence was blaringly apparent. Mrs. Goodnow, honing in on his insecurities, exclaimed "Dr. Percy! What does he know about anything except boats and tennis"⁵³⁸. With Nell's worsening condition, "Dr. Percy...was clearly frightened. I saw at once that he knew nothing at all about her case"⁵³⁹.

By the following summer, Dr. Percy, "dark and dapper, with a broad smile of welcome"⁵⁴⁰, showed definite progression. Nonetheless, Dr. Percy's maturation only began to unfold. He still displayed uneasiness while pinpointing a specific diagnosis to Mr. Elport's potentially serious complaints; "that railroad man Elport's sick and the young cub doesn't know what's the matter...indigestion, the pup thought, acute indigestion"⁵⁴¹. His competence was

⁵³⁶ibid., p.11.

⁵³⁷ibid., pp.9-10.

⁵³⁸ibid., p.5.

⁵³⁹ibid., p.20.

⁵⁴⁰ibid., p.77.

⁵⁴¹ibid., p.132.

further denigrated by the suggestion that "the big men [doctors]...turn the poor over to boys like that Percy to experiment with!"⁵⁴². Yet, Dr. Percy remained dedicated and returned to the settlement the following April "much befurred and bewrapped, looking pale and exotic in his city clothes. These he quickly threw off and plunged into the abundant work that offered"⁵⁴³ following a pneumonia outbreak. "The pup has the making of a man in him after all"⁵⁴⁴.

Several years later, with the Sanitarium's expansion, Dr. Farrold was no longer the struggling neophyte but a senior attending physician. "Dr. Percy was the System of the establishment, the efficient fly wheel without which it would have doubtless flown into a thousand pieces"⁵⁴⁵. Down at the Hospital, new patients were now greeted, admitted and tended by Dr. Percy. "If you [a new patient] want anything, I'll call Dr. Farrold...the young doctors, they carry out the cure, you know...shall I speak to Dr. Farrold?"⁵⁴⁶. At the novel's conclusion, following sixteen years of practice, Dr. Farrold had sufficient confidence to command authority within his social circle of acquaintances. It was he who assumed initial responsibility to guide Dorothy Holden towards her medical career. Trusted by the family who once mocked his abilities, he recounted tales of the Healing Spring's cures and mystiques, supplied the child with reprints of her

⁵⁴²Ibid., pp.143-144.

⁵⁴³Ibid., p.176.

⁵⁴⁴Ibid., p.176.

⁵⁴⁵Ibid., p.301.

⁵⁴⁶Ibid., p.319.

father's publications and, ultimately, encouraged the child to seek out her estranged father for further assistance⁵⁴⁷.

B. Character Integrity

"Character and gentility have always been criteria by which doctors and the medical profession have been judged"⁵⁴⁸. The Roman orator Quintilian defined a person of 'good character' as one whose values ensured appropriate assessment of a situation substantiated by proper action or correct behavior. As soon as the early eighteenth century, the concept of 'good character' had been integrated to American culture. By the early nineteenth century, 'character' connoted a model type of behavior necessary of any person attempting to influence social order⁵⁴⁹. Physicians readily met this criterion.

Victorian culture intimately linked the attainment of professional status to the possession of good character⁵⁵⁰. Physicians, in the 1860's, sought to capitalize on their goodness of character to elevate their professional authority. By 1898, character had become intimately associated with the physician. The United States Supreme Court ruled that character was as important a qualification as knowledge in judging a physician; states could rescind a medical license on the basis of inadequate character⁵⁵¹. Similarly, medical school

⁵⁴⁷Ibid., pp.427-431.

⁵⁴⁸Brieger, Classics and Character, p.90.

⁵⁴⁹Ibid., pp.88-109.

⁵⁵⁰Shortt, op.cit., pp.51-68.

⁵⁵¹Brieger, Classics and Character, p.92.

candidates were judged not only on cognitive capabilities but also on issues of character⁵⁵².

Character integrity possessed two independent components: the individual's internal mettle and his outward actions and manners that testified to his character. Each of these issues and their relation to the good doctor are discussed below.

i. Daniel Webster Cathell's Gentlemanly Catalog

In nineteenth-century American as well as British society, the gentleman reflected the ultimate expression of character integrity. A series of outward and inward characteristics reflecting good breeding marked the true gentleman. Inwardly, the gentleman possessed good character, active drive to improve his morals and a liberal education rooted in the classics. Outwardly, this translated into a manner of ease, grace and social polish. Dress, manners, general carriage and voice distinguished the gentleman⁵⁵³.

American physicians, since the 1830's, were concerned with personal character as it reflected on the professional image. Society regarded the physician as a gentleman; this image needed to be maintained. In what originated as an inspirational commencement speech tradition, established medical men preached to new graduates advising them on those gentlemanly elements most desirous in a physician. These orations reached the printed page and generated a flurry of advice manuals. They offered suggestions for maximizing education,

⁵⁵²Charles Eliot described the ideal Harvard man as possessing "knowledge, language and imagination. The American Academy of Medicine advocated "besides a sound body, quickness of perception, and a retentive memory, the candidate for medical study required absolute uprightness that included honesty, a sense of obligation to others, and a purity of spirit". *Ibid.*, pp. 91 & 92.

⁵⁵³*Ibid.*, pp.88-109.

marriage and business practice. This collection epitomized the Victorian American middle-class cult of sincerity. In the early Victorian period, physicians worked to emulate the sincere character, invoking earnestness combined with industry (essential to any professional) and usefulness merged with decisiveness (specific to the medical profession). Physicians realized that these character traits were only to be achieved through determined application. They labored to match this ideal. Following the Civil War, Victorians altered these ideals' prioritization. Culturally, there was a trend away from the earnest sincerity of a few decades previous; virtue was no longer the epitome of success. Physicians, hoping to increase their professional authority, still wished to retain their superior character image. Yet, the prevailing post-bellum philosophy was not "being what one wished to seem...it became more important to seem what one wished to be"⁵⁵⁴.

In 1882, Daniel Webster Cathell, responding to the bitter competition between regular physicians for the minority of paying patients, published the ultimate physicians' advice manual. Arguing that "it is necessary for even the most scientific physician to possess a certain amount of personal tact and business sagacity"⁵⁵⁵, he published a guide outlining those characteristics he considered most integral to a physician's future professional success. Essentially, he compiled those characteristics most apt to promote an outward gentlemanly image. Initially titled A Physician Himself and What He Should Add to the Strictly Scientific, the title was changed to the more appropriate Book on the Physician Himself and Things that Concern His Reputation and Success in 1899.

⁵⁵⁴Rebecca J. Tannenbaum, "Earnestness, Temperance, Industry: The Definition and Uses of Professional Character Among Nineteenth Century American Physicians", Draft (1993), p.3.

⁵⁵⁵Daniel Webster Cathell, Book on the Physician Himself from Graduation to Old Age, (Philadelphia, F.A. Davis Company, 1922), p.1.

Each year, a new edition was produced with the last being in 1922⁵⁵⁶. A full two generations of physicians accepted Cathell's advice. In his first chapter, *If luck has dealt you a good hand; strive to play it, for all its worth; if not, determine to play your poorer hand well*, Cathell selected those personal accoutrements he considered essential for commanding authority and subsequent professional and financial success. However, Cathell's claimed expertise notwithstanding, were these traits, appearances and mannerisms truly essential components of the good physician?

Cathell considered the aura a physician's office exuded an essential marker of professional success. Foremost, he suggested the optimal location. "If you begin practice in a city or a town, the location and appearance of your office will, more or less, affect your progress; and you will do well to select one easy of access; where the rich are neither too rich nor the poor too poor, but in a genteel upper-middle-class section; upon or very near one of the main thoroughfares...do not pitch your tent among common-place people in a run-down, going-to-wreck neighborhood, or where there is an overwhelming majority of the great unwashed"⁵⁵⁷. Dr. Sevier's office perfectly matched these criteria. "The main road to wealth in New Orleans has long been Carondelet street...Number 31/2, second floor, front was the office of Dr. Sevier. The office was convenient to everything. Immediately under its windows lay the sidewalks where congregated the men who, of all in New Orleans, could best afford to pay for being sick, and least desired to die. Canal street, the city's leading artery, was just below, at the near left-hand corner. Beyond it lay the older town, not yet impoverished in

⁵⁵⁶Lester S. King, "Medicine in the USA: Historical Vignettes XXII. Medical Practice: Making a Living", *JAMA*, vol. 251 (1984), pp. 1887-1892.

⁵⁵⁷Cathell, *op. cit.*, p.7.

those days,-the French Quarter. A single square and a half off at the right, and in plain view of the front windows, shone the dazzling walls of the St. Charles Hotel, where the nabobs of the river plantations came and dwelt with their fair-haired wives in seasons of particular anticipation, when it was well to be near the highest medical skill"⁵⁵⁸. He located precisely on the main thoroughfare and reached the desired upper-middle-class population. Tale of a Physician's Dr. Morte agreed. "My profession, that of a physician, requires me, a stranger in New York, to establish myself in a respectable neighborhood"⁵⁵⁹. In Elsie Venner, Holmes described a 'Doctor's Paradise' as "streets with only one side to them"⁵⁶⁰.

The Laflin College for the Eye and Ear, Dr. Bryson's office, was equally well located. "Situated in the very heart of the most typical of the great cities of America, less than two minutes' walk from all surface terminals and within the loop of the elevated systems...the businessman, pressed for time, finds it convenient to run in for hasty consultation"⁵⁶¹. Martin Arrowsmith, in Wheatsylvania, was offered the 'ideal office'-"above the general store...the finest location in town"⁵⁶². As a supplemental measure to meet Nautilus's smart set, Irving Watters advocated "join[ing] the country club and tak[ing] up golf. Best opportunity in the world to meet the substantial citizens"⁵⁶³.

⁵⁵⁸Cable, Dr. Sevier, pp.5-6.

⁵⁵⁹Davis, Tale of a Physician, p.100.

⁵⁶⁰Holmes, Elsie Venner, p.19.

⁵⁶¹Spearman, Doctor Bryson, pp.2-4.

⁵⁶²Lewis, Arrowsmith, p.148.

⁵⁶³ibid., p.211.

Spearman's Dr. Kurd attempted to populate his practice exclusively according to Cathell's ideal. He rented a room in a fancy hotel and attended church in an affluent community in hopes of "get[ting] his name up quicker"⁵⁶⁴. "He's looking for big patients-that's the reason he's so busy"⁵⁶⁵; he catered only to his rich clientele. June Borderly provided insight into his motivations. "D'you [Mrs. Eliot] know why he's so always so busy when you're waiting? Because you're not a big swell, with a carriage and footman, that can turn business to him"⁵⁶⁶. Even his secretary understood this policy. "But if Dr. Kurd had given her an appointment at the College why hadn't he kept it? Doctor Kurd never let profitable patients escape-he was the last man in the College to do that"⁵⁶⁷. Yet, Dr. Kurd's habits did not translate into good doctoring. Mrs. Eliot expressed her reservations. "I have to take Ruth down every other day and sometimes we have to wait so for him, and he is so busy. Sometimes, he seems to me almost indifferent. Delay and anxiety-and expense-the expense is fearful"⁵⁶⁸.

Dr. Rast's practice, however, directly countered Cathell's model. He opened his practice in the Lower East Side noted for its "miles of stairways...blocks of rats' nests-cellar, attics, and seven-in-a-room sweat-holes...all this squalor and misery and nastiness so in the mass...the East Side is overrun with vermin"⁵⁶⁹. Yet, the very location of Dr. Rast's practice

⁵⁶⁴Spearman, Doctor Bryson, p.17.

⁵⁶⁵Ibid., p.19.

⁵⁶⁶Ibid., p.17.

⁵⁶⁷Ibid., pp.6-7.

⁵⁶⁸Ibid., p.16.

⁵⁶⁹Oppenheim, Doctor Rast, pp.225-226.

necessitated his story's telling. "If a man wins a battle he goes down in a biography; and just because you are buried here on the East Side, unknown and unknowable, working alone and obscure-why for that reason alone you ought to be put down in writing-just to show that the common, the everyday, the private hero-life is as great as any other"⁵⁷⁰. Cathell stipulated that "where there is nothing great to be done, a great man is impossible, and the impossible never occurs, and minimum success is the only outlook in such a field"⁵⁷¹. Dr. Rast defied Cathell's challenge. He established himself among 'the great unwashed' in an area assumed to have no potential for greatness. Nonetheless he lived a hero's life, achieving greatness and popularity.

Drs. Holden and Nye joined Dr. Rast in becoming successful, respected practitioners who disregarded Cathell's advice to attract a middle-class clientele. Dr. Nye was described as "absolutely impractical. [He] would leave a rich summer patient and go see a no-account Portygee that he thought needed him more, even though he knew he would never get a cent for it"⁵⁷². Dr. Holden specifically abhorred the city. He admitted that "one cannot heal in the city, too many traders, too much reward. He waved a scornful hand over the smiling landscape of Suburbia, and dismissed it"⁵⁷³. Dr. Holden dedicated himself to the Native communities and the stranded logging crews. Often, "he was forced to make long journeys, an entire day over the ice in a sleigh, or ten miles on stout snow-shoes,

⁵⁷⁰Ibid., p.7.

⁵⁷¹Cathell, op. cit., p.5.

⁵⁷²Lincoln, Dr. Nye, p.44.

⁵⁷³Herrick, Healer, p.88.

to look after some woodsman tossing in fever in some squalid bunk house"⁵⁷⁴. He travelled "to Temisko, twenty-five miles, in all that storm last week, to see a half-breed"⁵⁷⁵. Standing by his people, he earned a legendary status in the northern backwoods.

Dr. Holden, after fire torched his spa, established a new practice in the 'wilderness' of a dingy, urban working class neighborhood. Again he neglected Cathell's suggestions. He found "a little brick box of a house, one of a dingy row set back from the street...so he hung out his sign over his door,-a modest wooden board that could hardly be read across the street"⁵⁷⁶. Not only was the house small, dingy and set back from the street, but his sign did not boldly advertise his practice. However, in a neighborhood crowded with "doctors, doctors, doctors! As many doctors as teachers, more doctors than ministers of the gospel", Cathell's advice would have proven useful. Cathell would have snickered as Dr. Holden "waited many weeks before the first patient entered the brick house in search of aid"⁵⁷⁷.

There was, however, one practice criterion that did distinguish the good doctor: practice size. Dr. Nye, upon his return to Ostable, faced the daunting task of reestablishing a medical practice within an unaccepting community. Within a couple of months, the townsfolk reconsidered their position. Recognizing that "his practice is growing all the time" they softened their views and acknowledged that "there must be something to him all the same"⁵⁷⁸.

⁵⁷⁴ibid., p.88.

⁵⁷⁵ibid., p.132.

⁵⁷⁶ibid., p.407.

⁵⁷⁷ibid., p.407.

⁵⁷⁸Lincoln, Dr. Nye, p.223.

Conversely, Dr. Wendell's diminutive practice attested to his failings. His sister, Ann, monitored the situation. "'Ezra, is your practice growing?'"⁵⁷⁹. Dr. Wendell's meek reply spoke to the contrary.

Cathell prescribed strict limitations for furnishing the physician's office. "Try to have a nice, comfortable, cheerful waiting-room, with a recessed front door...let their essential features show that their occupant is possessed of good breeding and cultivated taste, as well as learning and skill...the office, the sanctum-of an earnest, working scientific medical man who has a library, takes the journals, and makes full use of the instruments of precision...keep from sight such inappropriate and repulsive objects as catheters, syringes, stomach-pumps...skeletons, grinning skulls, jars of amputated extremities, tumors, the unripe fruit of the uterus...see that the walls and floors are tastefully covered"⁵⁸⁰.

Roscoe Geake, the otolaryngologist cum office furniture salesman, preached the same ethic to Martin Arrowsmith's medical school class. "The graduates of the University of Hard Knocks judge a physician as they judge a businessman...Nothing is more important in inspiring him than to have such an office that as soon as he steps into it, you have begun to sell him the idea of being properly cured...I don't care whether he has all science at his fingertips...If he has a dirty old office, with hand-me-down chairs and a lot of second-hand magazines, then the patient isn't going to have confidence in him"⁵⁸¹. To please all varieties of practitioners, he offered various furnishing styles. "Have your potted palms and handsome pictures-to the practical physician, they are as

⁵⁷⁹Mitchell, In War Time, p.133.

⁵⁸⁰Cathell, op. cit., p.10.

⁵⁸¹Lewis, Arrowsmith, pp.85-86.

necessary a part of his working equipment as a sterilizer or a Baumanometer. But so far as possible have everything in sanitary-looking white...Rich golden or red cushions, in a Morris chair enameled the purest white! A floor covering of white enamel, with just a border of delicate rose..."⁵⁸².

Yet, the novels' physicians eschewed Cathell's 'dignified' style. Elsie Venner's Dr. Kittredge kept but a meager collection of medical books⁵⁸³. However, he prided over his specimen room. "It was a place such as anybody but a medical man would shiver to enter. There was the usual tall box with its bleached rattling tenant; there were jars in rows where 'interesting cases' outlived the grief of widows... in alcoholic immortality; there were various semipossibilities of minute dimensions of unpromising developments; there were shining instruments of evil aspect"⁵⁸⁴. All were objects Cathell specifically stated not to display. Yet, Dr. Kittredge was "the leading physician of Rockland"⁵⁸⁵. Doc Vickerson, Martin Arrowsmith's boyhood mentor, similarly outfitted his office. "This central room was at once business office, consultation room, operating theater, living room, poker den and warehouse for guns and fishing tackle. Against a brown plaster wall was a cabinet of zoölogical collections and medical curiosities, and beside it...a skeleton with one gaunt gold tooth"⁵⁸⁶. The Doc bragged about his choice specimens. "'Look here! See that? In the bottle? It's an appendix. First one ever took out around here. I did it!'"⁵⁸⁷. Dr. Bryson's

⁵⁸²Ibid., p.86.

⁵⁸³Holmes, Elsie Venner, p.210.

⁵⁸⁴Ibid., p.215.

⁵⁸⁵Ibid., p.98.

⁵⁸⁶Lewis, Arrowsmith, p.3.

⁵⁸⁷Ibid., p.5.

office modeled an austerity more extreme than Cathell's fashionable whitewash. "The little room was lighted by a student lamp, green shaded...The office was simply provided. A table supported some shelves of books. On the opposite wall hung an engraving of 'The Doctor'. The floor was laid in parquetry; two or three chairs and a pair of revolving stools made up the equipment"⁵⁸⁸.

A carefully selected physician's wardrobe held equal importance to his office's furnishings. Cathell advised to "be neither a fop who spends two hours in dressing nor a sloven, but keep yourself neat and tidy from head to foot...do not altogether ignore the fashion of the day...good clothes may not make a man but they do give him increased dignity and confidence in himself...even though you be ever so poor, let your garb show genteel poverty"⁵⁸⁹. To these ends, he catalogued specific accessories a physician should include in his daily toiletries: "clean hands, well-shaved face or neatly-trimmed beard, unsoiled shirt and collar, unimpeachable hat, polished boots, spotless cuffs..."⁵⁹⁰. The Healer's Dr. Eliot Farrington, "a good example of the new doctor, to be found perhaps in its full development only in the United States,...the most marked of all the 'rising men' in the profession"⁵⁹¹, carefully adopted this mantra. "Farrington's appearance showed what care and precision in the smaller details of dress can do even with the conventionalized garb of to-day...He was exactly right from his small pearl studs to his crisp cravat... Any one anywhere could tell at a glance

⁵⁸⁸Spearman, Doctor Bryson, p.22.

⁵⁸⁹Cathell, op. cit., p.26.

⁵⁹⁰Ibid., p.26.

⁵⁹¹Herrick, Healer, p.262.

that this man had always had the habit of good clothes and good society"⁵⁹². Similarly, Lewis's Angus Duer always arrived "precisely well-dressed"⁵⁹³ as he marched towards becoming the 'Brilliant Young Surgeon'.

Dr. Bryson also maintained a well-groomed appearance. "Brushing his hair, he saw his face in the mirror and looked at his features critically and with a new curiosity. He walked to the washstand and began washing his hands...Bryson kept washing, washing, washing his hands. It was such a resolute pleasure, hand washing...He washed his hands one hundred times a day, for sometimes he cast up matters as often as that with himself and there was the constant danger of infection"⁵⁹⁴.

Other physicians paid no attention to their dress. At work in the wilderness, Dr. Holden wore flannel and woolen clothing⁵⁹⁵. Even in refined city society he made no effort to impress high fashion. He possessed "ancient dress clothes and his cravat rumpled untidily about his high collar...he refused to order new clothes"⁵⁹⁶. Dr. Wendell circulated with his army uniform improperly buttoned and generally disheveled⁵⁹⁷.

Cathell stressed that "public opinion is our supreme court...a good reputation is...the chief source of every medical man's patronage"⁵⁹⁸. However,

⁵⁹²Ibid., p.263.

⁵⁹³Lewis, Arrowsmith, p.272.

⁵⁹⁴Spearman, Doctor Bryson, p.54.

⁵⁹⁵Herrick, Healer, p.21.

⁵⁹⁶Ibid., p.263.

⁵⁹⁷Mitchell, In War Time, p.3.

⁵⁹⁸Cathell, op. cit., p.12.

contrary to Cathell's emphasis, dress served as a poor predictor of the good physician. The impeccably dressed Dr. Farrington created the illusion of a good physician but lacked genuine interest in his trade. Dr. Bryson, equally attentive to his personal hygiene, carried a most positive reputation. Similarly, the shabbily dressed Dr. Holden earned his patients' respect yet Dr. Wendell did not.

Owning transportation afforded the physician more than respectability. "A riding physician has several advantages over the one who makes his rounds on foot. Not only is Dr. Rider able to see a greater number of patients in a given time, and with much less wear and tear to himself, but he gets brain-rest while riding from one house to another, and can spend that time in thinking...when he reaches a patient he is in better mental and physical condition to begin his duties than Dr. Walker, who arrives tired, out of breath from foot-work...another advantage is that Dr. Vehicle can salute acquaintances as his automobile or carriage meets them and ride on...you should, therefore, get a moderate-price but up-to-date automobile, or a good-looking horse and a genteel carriage, as soon as your practice will at all justify "⁵⁹⁹.

Dr. Kittredge "kept three or four horses, sometimes riding in the saddle, commonly driving in the sulky"⁶⁰⁰. The Doctor's carriage grew to symbolize the Doctor himself, preambing his professional calls. "Whenever the narrow sulky turned in at a gate, the rustic who was digging potatoes...stopped and looked up at the house the Doctor was visiting"⁶⁰¹. Moreover, Dr. Kittredge's use of

⁵⁹⁹Ibid., p.37.

⁶⁰⁰Holmes, Elsie Venner, p.98.

⁶⁰¹Ibid., p.139.

transportation modeled Cathell. "It never occurred to him to think of walking to see any of his patients' families"⁶⁰².

Dr. Sevier's call to "order my carriage"⁶⁰³ attested to his possession and use of the transport. Traffic jams, where "one of those little white omnibuses...crowd[ed] in before his carriage"⁶⁰⁴, frustrated the Doctor. Rushing to the Richlings, "the Doctor's carriage was hurrying across Canal Street"⁶⁰⁵.

Dr. Wendell, recognizing its suggested status, yearned for the physician's carriage. "The question of horse and carriage became a subject of discussion between the brother and sister; but despite need for them, too much immediate expenditure was involved for more than mere thought at the present"⁶⁰⁶.

By 1910, the automobile had replaced the horse and buggy as the physician's preferred mode of travel⁶⁰⁷. In describing his career aspirations, the adolescent David Noble decreed "I'd learn to be a doctor-the kind that cuts people up and sews 'em up again-a surgeon. And I'd have an ottermobile-I've been reading about 'em in a magazine"⁶⁰⁸. Dr. Nye championed a 'walking practice. However, with "his practice among the poorer element larger, considerably so"⁶⁰⁹, he indulged in the purchase of "the ancient 'flivver' from Captain Mark

⁶⁰²Ibid., p.139.

⁶⁰³Cable, Dr. Sevier, p.71.

⁶⁰⁴Ibid., p.11.

⁶⁰⁵Ibid., p.13.

⁶⁰⁶Mitchell, In War Time, p.44.

⁶⁰⁷Lester S. King, "Medicine in the USA: Historical Vignettes XXIII. The Automobile Makes an Impact", *JAMA*, vol. 251 (1984), pp.2352-2355.

⁶⁰⁸Keyes, David Noble, p.13.

⁶⁰⁹Lincoln, Dr. Nye, p.263.

Bearse"⁶¹⁰. "Thereafter, the professional visits of Ephraim Nye, M.D., were literally noised abroad"⁶¹¹. Transportation, integral to every physician's practice, failed to distinguish the good from the ordinary physician.

Cathell's final point restricted the physician's extracurricular pursuits. He suggested that physicians ought to "prefer to spend your unoccupied time in your office with standard medical works and journals, or in getting keenness, culture and development of your better parts"⁶¹². Common vices, including "loitering around drug-stores, hotel-lobbies, saloons, club-rooms, cigar-stores, billiard-parlors...or join[ing] the throng at the base-ball game, or touring in your automobile...[and] what shall be said...of drinking and of gambling"⁶¹³ were unacceptable. He admonished "if you have laid down your crown of manhood and entered either of these roads...flee from that company and do not turn back"⁶¹⁴. Here, Cathell was right. Dr. Hesselink advised Martin Arrowsmith to adopt intellectual extracurricular interests. "Read medical journals...There's enough inspiration for me in trying to help the sick...How much do you read?"⁶¹⁵. Dr. Arrowsmith, however, preferred other less wholesome pursuits which ultimately jeopardized his Wheatsylvania career. Local gossip branded him as "a brainy man-very well informed...likes his booze awful well...suppose he's drunk and gets called out on a case...great on books and study but he's a free

⁶¹⁰Ibid., p.263.

⁶¹¹Ibid., p.267.

⁶¹²Cathell, op. cit., p.14.

⁶¹³Ibid., pp.14-15.

⁶¹⁴Ibid., p.15.

⁶¹⁵Lewis, Arrowsmith, pp.169-170.

thinker-never goes to church...great mistake for any doctor not to identify himself with some good solid religious denomination...It's too bad Arrowsmith goes drinking and helling around and neglecting his family and patients. I can see his finish"⁶¹⁶. Due to his privileged professional status, society held the physician to the highest standard of social conduct.

ii. Moral Obligations

The medical profession, establishing their professional identity in the 1840's, significantly intertwined morality with their quest for professional authority. The 1840's society regarded physicians in low esteem. By adopting superior moral conduct, physicians hoped to attain higher levels of regard⁶¹⁷. For its inception, the American Medical Association adopted a code of ethics that held all members to a standard of moral conduct⁶¹⁸. The code's priorities were clear. He "who did not hold the proper beliefs was not a proper physician"⁶¹⁹.

Through the latter half of the nineteenth century, the medical profession standardized itself with moral superiority. Unacceptable behavior included "rudely and peremptorily refusing to pay his assessments; exhibiting hostility, disparagement, and contempt to the [medical] Society...and other irregular and

⁶¹⁶Ibid., p.178.

⁶¹⁷In the 1840's, physicians fought for the "right to be attentively and respectfully listened to [with] at least the same respectful and considerate attentions that are paid as a matter of course and apparently without constraint to the clergyman...and to the lawyer". Lester S. King, "Medicine in the USA: Historical Vignettes V. The 'Old Code' of Medical Ethics and Some of the Problems It Had to Face", *JAMA*, vol. 248 (1982), p.2329.

⁶¹⁸The 1840's medical profession's diversity precluded selection on any other criteria. Although the code was specifically targeted against sectarians, the AMA could not invoke any educational clauses. A significant number of regular practitioners were grossly undereducated and fail even the most lenient criteria. The AMA chartered the regular physician to distinguish himself through not only professional allegiance but through superior moral conduct. Ibid., pp.2329-2333.

⁶¹⁹Ibid., p.2331.

disreputable acts, equally adverse to...the dignity of the profession"⁶²⁰. Society expected the physician to maintain the confidentiality of the doctor/patient encounter⁶²¹. Medical students possessing "absolute uprightness that included honesty, a sense of obligation to others and purity of spirit"⁶²² were actively recruited. Morality equally motivated the 1882 AMA code revisions⁶²³. In the 1890's, Richard Cook Cabot, the eminent Harvard hematologist, dedicated his life to preaching and protecting the medical profession's expectations for morality⁶²⁴. Similarly, each novel equated upstanding moral conduct with the good doctor.

Davis presented Dr. DuBois with quintessential morality. "He was possessed of the highest intellectual and moral endowments; a deep thinker, benevolent to a fault and constant in his friendships"⁶²⁵. A physician's intellectual success was intimately linked to his attainment of moral superiority. Spearman reflected Dr. Bryson's moral integrity through the doctor's unbounded generosity. He "pitied [Mrs. Eliot] when [she] was helpless, gave [his] skill like water, like air, like sunshine to save Ruth"⁶²⁶. Dr. Rast's community

⁶²⁰Ibid., pp. 2329-2333.

⁶²¹Burns, Fictional Doctors and Medical Ethics, pp.39-55.

⁶²²Brieger, Classics and Character, pp.88-109.

⁶²³One delegate suggested a clause outlining the only ethical offenses as "those comprehended under the commission of acts unworthy of a physician and a gentleman". Lester S. King, "Medicine in the USA: Historical Vignettes IX. The AMA Gets a New Code of Ethics", *JAMA*, vol. 249 (1983), p.1338.

⁶²⁴Cabot, a scientist himself, recognized the dangers in science supplanting the physician's traditional ethical motivations. He advocated equal attention to science and art. Failing this, medicine risked becoming a "dehumanized instrument of bureaucratized secular authority". Laurie O'Brien, "A Bold Plunge into the Sea of Values: The Career of Dr. Richard Cabot", *New England Quarterly*, vol. 58 (1985), pp.533-553.

⁶²⁵Davis, Tale of a Physician, p.37.

⁶²⁶Spearman, Doctor Bryson, p.162.

acknowledged his superior carriage-"he is no schnorrer [persistent mooch(Yiddish)]"⁶²⁷. The moral Dr. Kittredge professed no prejudices against mankind. "I can't judge men' souls. I can judge their acts and hold them responsible for those-but I don't know much about their souls"⁶²⁸. Due to practicing this philosophy, Dr. Kittredge obtained custody of Dick Venner following the latter's arrest for attempted murder. "The good people so respected and believed the doctor that they left the prisoner with him...the doctor will treat him like a human being at any rate"⁶²⁹.

Dr. Sevier, "straight-up in his austere pure-mindedness"⁶³⁰, carried morality to an overdone extreme. "Shall we condemn the fault?"⁶³¹. Cable answered his own question-"yes"⁶³². He revolved his professional career around the moral tenet of "the rectitude of mankind...to demolish evil-that seemed the finest of aims...To face evil in its nakedness and to inveigh against it in high places and low seemed the consummation of all manliness; and manliness was the keynote of his creed"⁶³³. Dr. Sevier, unfamiliar with the wants and trials of poverty, disdained the poor. Upon meeting street beggars, "he passed by, but faltered, stopped, let his hand down into his pocket and looked around to see if this pernicious example was observed. None saw him...Weak and dazed...he

⁶²⁷Oppenheim, Doctor Rast, p.76.

⁶²⁸Holmes, Elsie Venner, p.402.

⁶²⁹Ibid., p.377.

⁶³⁰Cable, Dr. Sevier, p.7.

⁶³¹Ibid., p.9.

⁶³²Ibid., p.9.

⁶³³Ibid., p.7.

turned and dropped a dime into the beggar's cup"⁶³⁴. Dr. Sevier relaxed his extreme moral severity only after the Richlings redirected his assumptions on the causality of poverty.

Practicing ethical medicine was considered an extension of a physician's morality. Upon his return to Ostable, Dr. Nye respected his established colleagues' rights. He "would not, unless forced to do so, take away a patient from his fellow physician"⁶³⁵. Dr. Wendell, recognizing his breach of the physician's moral code, cringed at his own blatant denial of malpractice. "Wendell was more disturbed by this necessity of disobeying the habitual moral code of his profession than by mere fact of the lie itself"⁶³⁶. He grew progressively haunted by his breach of morality. "Thoughts, which rose unsummoned like ghosts, startled him and filled his mind with new and horrible suggestions of future risks and dangers. Vivid and terrible images of the fatal moment of haste came before him"⁶³⁷. Dr. Wendell readily recognized this failing. The good physician, at all times, was expected to uphold his superior moral standing.

II. The Physician's Source of Authority

Shortt presented that any professional organization represented a heterogeneous collection of individuals gradually recognized by both themselves and society as a homogeneous and cohesive group. Essential to this cohesiveness was a centralizing body of knowledge and ideology. Authority would be drawn by

⁶³⁴Ibid., p.157.

⁶³⁵Lincoln, Dr. Nye, p.89.

⁶³⁶Mitchell, In War Time, p.215.

⁶³⁷Ibid., p.220.

referring to this anchoring source⁶³⁸. In establishing its authority, the medical profession adhered to this basic principle of organization. Cohesiveness, however, assumed a steady, constant knowledge base. Between 1859 and 1925, the medical profession's knowledge base underwent tremendous revision and amplification. Attempting to reconcile these fluctuations, the medical profession sought its authority from several, often conflicting, sources.

Three sources of authority-the principle of specificity, nature and scientific advancement-figured most prominently between 1859 and 1925. Their relative importance and individual evolutions are considered below.

A. The Principle of Specificity

The theory of specificity defined the manner in which nineteenth-century physicians dispensed therapeutics. Medicines were not solely selected based on the presenting pathophysiology. Instead, the theory of specificity promoted an "individualized match between medical therapy and the specific characters of a particular patient and of the social and physical environments"⁶³⁹. Variables such as the patient's body habitus, sex, temperament, race, social class as well as environmental factors including climate and precipitation carried major influence in choosing a therapeutic. Regionality played an important role. Diseases were expected to follow different courses in northern versus southern climates and consequently required different management. A northern medical school graduate was considered ill-prepared to practice medicine along the gulf coast. Responsible medical practice assumed the ability to assess an individual patient's specific needs. Application of the theory of specificity separated the

⁶³⁸Shortt, Physicians, Scientists and Status, pp.51-68.

⁶³⁹Warner, Therapeutic Perspective, p.58.

regular physician from the sectarians. The profession also dismissed regular practitioners who ignored the theory as ethical quacks⁶⁴⁰.

A patient's specific characteristics were divided into two categories: constitution and temperament. Constitution, highly individualized, reflected "the sum of all the influences of locality, station, hygiene, occupation, habit, diet or accident which have acted upon the individual from the time of his birth, until the period of the disease we are treating"⁶⁴¹. No two individuals possessed an identical constitution. The physician was challenged to appreciate each patient's constitutional nuances. Temperament offered broader divisions. Rooted in Hippocrates' four humors, temperament categorized patients into characteristic physiognomies, behaviors, types of disease and therapeutic requirements. Temperament was not only a individual characteristic. Climates possessed unique temperaments. Nations and ethnic races and socio-economic classes also had uniquely characteristic temperaments. Blacks required different treatment than whites. Immigrants were classified according to their native country. Laborers received lowering treatments; more refined classes received stimulants⁶⁴².

Beginning in the 1860's the proliferation of disease-specific treatments⁶⁴³ argued for the disintegration of the principle of specificity. Irrespective of a luetic

⁶⁴⁰Ibid., pp.59-60.

⁶⁴¹Ibid., p.64.

⁶⁴²Ibid., p.64-65.

⁶⁴³Quinine for malaria, mercury for syphilis and digitalis for dropsy were the first set of disease-specific treatments. Each was popularized prior to the 1860's. Warner, Therapeutic Perspective, p.62. Through the 1870's and 1880's, this list substantially grew. New additions included the opiates, cocaine, salicylates, chloral hydrate and antipyrine. Warner, Ideals of Science, pp.454-478.

patient's constitution, temperament or regional circumstances, he received mercury. Increasing the subset of diseases possessing predetermined therapeutic regimens slowly faded the principle of specificity into obsolescence. Whereas the 1860's novels repeatedly relied on the principle, the only novels beyond this decade to invoke this authority were Dr. Sevier (1885) and The Career of David Noble (1921).

Holmes rooted his character descriptions within the framework of constitution and temperament. Mrs. Peckham "was from the West, raised on Indian corn and pork, which give a fuller outline and a more humid temperament, but may perhaps be thought to render people a little coarse-fibered"⁶⁴⁴. Translated into a more common English, she was "an honest, ignorant woman. She could not have passed an examination in the youngest class"⁶⁴⁵. Davis recognized the reliance on an individual's constitution when uncovering personality predispositions. He further suggested that one's constitutional formation began in utero. "Any educated physician...would have detected a certain horrible and wretched event in his mother's biography and connected it with the subsequent development of this alarming inconsistency"⁶⁴⁶.

Dr. Kittredge applied the principle of specificity to demonstrate Indian or Gypsy moral inferiority. "There is some apparently congenital defect in the Indians, for instance, that keeps them from choosing civilization and Christianity. So with Gypsies, very likely. Everybody knows that Catholicism or Protestantism is a good deal a matter of race. Constitution has more to do with

⁶⁴⁴Holmes, Elsie Venner, p.48.

⁶⁴⁵Ibid., p.48.

⁶⁴⁶Davis, Tale of a Physician, p.10.

belief than people think for"⁶⁴⁷. In War Time's Dr. Lagrange attributed Morton's poor convalescence to constitutional elements. "We have only of late felt so uneasy. It is a question of strength of constitution, of physical endurance, and of power to take food. How competent these will prove, no one can tell"⁶⁴⁸.

Dr. Sevier, on several occasions, rested his prognoses on the principle of specificity. Estimating Richling's chances of surviving yellow fever, he explained that "the proportion [of people sick with yellow fever actually dying] varies in different seasons; say about one in seven or eight. But your chances would hardly be so good, for you're not strong, Richling, nor well either"⁶⁴⁹. Dr. Sevier implicated both seasonal temperament and constitution as important variables. Regional temperament motivated his assessment of the Kentucky plantation owner's wife; "the climate of New Orleans had not responded with that hospitable alacrity which was due so opulent, reasonable and universally obeyed a guest"⁶⁵⁰.

David Noble mused on the effects of Jacqueline's religious, peasant lifestyle on her previously opulent constitution. Jacqueline had had a routine operation and received standard post-operative management. Yet, her situation remained critical. Specifically, he worried about her lifestyle change affecting her postoperative recovery. "Jacqueline, he suspected, had observed the fasts of her church more conscientiously than she had done its feasts, even if the abrupt change from luxurious living to coarse peasant fare had not inevitably wrought

⁶⁴⁷Holmes, Elsie Venner, pp.316-317.

⁶⁴⁸Mitchell, In War Time, p.48.

⁶⁴⁹Cable, Dr. Sevier, p.281.

⁶⁵⁰ibid., p.68.

havoc...Moreover, her taste for beauty and pleasure, her emotions, her senses, had not died the natural death that comes from peaceful middle age; they had been torn up by the roots with her own hands, trampled on with her own feet"⁶⁵¹. Where disease-specific reasoning failed, even a 1920's physician resorted to the principle of specificity.

Both Dr. Rast and Dr. Nye, however, disproved one offshoot of the principle of specificity; the differing medical needs of poor immigrant populations⁶⁵². Dr. Rast did not distinguish among his poor Jewish immigrants and treated each with the current standard of care. He offered a tuberculous patient the option of a suburban sanitarium. He sent messengers for drugs and oxygen to relieve pneumonia. His people were an equal part of "the Human Deeps-the power behind faces-the love that breathes through all- the hint, the reminder of the common man to be, the Brotherhood to be"⁶⁵³. Dr. Nye treated his Portuguese community with the same kindness and medical expertise as he did Faith Copeland, Cyrenus Stone and the rest of Ostable's affluent community.

B. Nature

During the first two thirds of the nineteenth century, the physician deferred to Nature as the both the cause of disease and the principal instrument towards restoring health. The healthy human organism was regarded in harmony with Nature. Sickness implied a perturbation of this balance. The physician considered himself Nature's agent, representing Nature in the

⁶⁵¹Keyes, David Noble, p.246.

⁶⁵²Ronald L. Numbers and John Harley Warner, "The Maturation of American Medical Science", in Sickness and Health in America, ed. by Judith Walzer Leavitt and Ronald L. Numbers, (Madison, WI, University of Wisconsin Press, 1985), p.119.

⁶⁵³Oppenheim, Doctor Rast, p.238.

sickroom. The physician not only relied on the body's own natural healing powers to restore an upset equilibrium but also administered therapeutics directed towards correcting the diseased system⁶⁵⁴. In the course of patient care, the novels' physicians relied on Nature's authority to reinforce their professional position.

Dr. Boynton acknowledged "our sympathetic relations with nature are subtle and strong. No one can tell just how much influence they have on our physical condition"⁶⁵⁵. Dr. Sevier stated his reliance on Nature. "Why, Richling, you're a bible-man, eh? Well, yes, I think you are. But I want you never to forget that the book of Nature has its commandments too; and the man who sins against them is a sinner...Do as a good doctor would-help Nature"⁶⁵⁶.

In Elsie Venner, Dr. Kittredge argued that Nature, rather than diverging from religion, intricately enmeshed with canonical beliefs. Countering Reverend Fairweather's suggestion that "don't you think that your profession is apt to see 'Nature' in the place of the G-d of Nature-to lose sight of the first cause in their daily study of secondary causes"⁶⁵⁷, Dr. Kittredge opined that "nobody believes in G-d and trusts G-d as much as the doctors...We think that when a wound heals, that G-d's presence and power and knowledge are healing it, just as much as the Old Surgeon [Galen] did"⁶⁵⁸.

⁶⁵⁴Warner, Therapeutic Perspective, pp.85-86.

⁶⁵⁵Howells, Undiscovered Country, p.192.

⁶⁵⁶Cable, Dr. Sevier, pp.289-290.

⁶⁵⁷Holmes, Elsie Venner, p.314.

⁶⁵⁸Ibid., p.314.

By the 1870's the medical profession started to abandon its ideal of a natural etiology for illness. Medical science began to target specific organs as the culprits for disease. Quantitative bedside measurements including temperature, pulse and blood pressure endowed previously subjective symptomatology with objective data. Shifting his perspective from a 'natural' state of good health, the physician recognized 'normal' pulse and temperature readings. Illness was no longer considered a 'systemic imbalance' but a 'deviation from the norm'. Therapeutics no longer engaged a war with nature but served to simply correct abnormal physical parameters⁶⁵⁹. Despite this change in therapeutic perspective, Drs. Holden and Noble, two twentieth-century physicians continued to carry Nature as a source of authority.

Referring to the Healing Spring, Dr. Holden reflected that "yet there is a reason for the faith, too, more or less mystical but satisfying to the human heart. Through the water, the sick return to nature. The water itself comes from within the earth, the heart of nature...peace of body and mind"⁶⁶⁰.

David Noble not only reaffirmed his ties to nature but specifically rejected the medical profession's espousal of physiologic norms. Jacqueline's complicated recovery raised her concern for further setbacks. She looked imploringly at David "I-oh David! Don't say this isn't normal"⁶⁶¹. Dr. Noble, however, dismissed her fears. "I'm not going to-I hate that word anyway. It may not have been normal, but it was perfectly natural"⁶⁶². Having devoted his entire surgical career to

⁶⁵⁹Warner, Therapeutic Perspective, pp.86-87.

⁶⁶⁰Herrick, Healer, p.40.

⁶⁶¹Keyes, David Noble, p.252.

⁶⁶²Ibid., p.252.

recreating the normal state, David Noble was frustrated by its limitations. Specifically, Dr. Noble rejected the corollary of 'normalcy', the concept that 'abnormal' automatically implied an undesired state.

C. Scientific Advancement

Commencing in the 1880's, American physicians centered a perpetually increasing portion of their professional authority on their grasp and pursuit of science. Science not only nodded towards the physician's educational attainment⁶⁶³ but also symbolized the leaping advances affecting medical practice.

Dr. Rast reflected in exasperation during a challenging case. "He had done all that he-all that Science-could do"⁶⁶⁴. Dr. Bryson rested his professional authority on his grasp of the scientific spirit. Describing to Mrs. Eliot a case of hysterical myopia, he reinforced his position with contemporary scientific data. "Somewhere between the optic nerve and the brain in that child's head there is a hitch in the connection of impression. There is not the slightest physical difference made in her sight by adding these glasses. Yet, when I tell her she can see with them, she sees"⁶⁶⁵. Dr. Bryson explained that her vision was improved upon his suggestion-"hypnotism is a bigger word for it. I bid her to see and she sees"⁶⁶⁶. Yet, when Mrs. Eliot asked him if he were a hypnotist, he staunchly

⁶⁶³Science had become "the intellectual ratifier of the new world order". Shortt, op. cit., p.61.

⁶⁶⁴Oppenheim, Doctor Rast, p.105.

⁶⁶⁵Spearman, Doctor Bryson, p.115.

⁶⁶⁶Ibid., p.115.

exclaimed that "I am not. I disavow the name"⁶⁶⁷. As a man of science, he denied any connections to the pseudoscientific branches of medicine.

Almus Pickerbaugh, Nautilus's chief public health officer, recognized science's influential power. In his own position, he established "a regular practice to set aside a period for scientific research, without a certain amount of which even the most ardent crusade for health methods would scarcely make much headway"⁶⁶⁸. Dr. Pickerbaugh, however, drew his authority from science's sensationalist power rather than its technical promise. To validate his health policies, he studded his reports with "bogus statistics". He also recoiled from any challenges to his data. "He believed that because he was sincere, therefore his opinions must always be correct"⁶⁶⁹.

Dr. Boynton's recounting of the true scientific spirit emphasized Dr. Pickerbaugh's misuse of scientific authority. In The Undiscovered Country Dr. Boynton recounted: "I have heard a story of Agassiz to the effect that when he had read some book wholly upsetting a theory he had labored many years to establish, he was so glad of the truth that his personal defeat was nothing to him. He exulted in his loss because it was the gain of science. I have not the magnanimity of Agassiz, I find, though I have tried to pursue my inquiries in the same spirit of scientific devotion"⁶⁷⁰. Dr. Pickerbaugh refused to accept any scientific truth other than his own.

⁶⁶⁷Ibid., p.116.

⁶⁶⁸Lewis, Arrowsmith, p.195.

⁶⁶⁹Ibid., p.225.

⁶⁷⁰Howells, Undiscovered Country, p.358.

A condition of assuming scientific authority was the subsequent rejection of medical empiricism. Martin Arrowsmith first declared his scientific authority in medical school upon challenging his *materia medica* professor. "He inquired and publicly, 'Dr. Davidson, how do they know ichthyol is good for erysipelas? Isn't it just rotten fossil fish-isn't it like the mummy-dust and puppy-ear stuff they used to give in the olden days?'"⁶⁷¹. The empiricist answer of "how do they know? Why, my critical young friend, because thousands of physicians have used it for years and found their patients getting better, and that's how they know...I would try to convince you that my statements may be accepted, not on my humble authority, but because they are conclusions of wise men-men wiser or certainly a little older than you, my friend-through the ages"⁶⁷² only increased his irritation.

III. The Challenge of The Old/Experience vs. The Young/Science

Seeking to establish his authority, the regular American physician was perpetually challenged to communicate his professional competence. In the 1830's and 1840's, both botanical and infinitesimal sectarians⁶⁷³ as well as the regular profession's 'therapeutic nihilists'⁶⁷⁴ questioned the usefulness and

⁶⁷¹Lewis, Arrowsmith, p.41.

⁶⁷²Ibid., pp.41-42.

⁶⁷³Discussions on Thompsonianism, Eclecticism and Homeopathy can be found in Starr, op. cit., pp.51-54, 95-99.

⁶⁷⁴Therapeutic 'nihilists' included regular physicians who openly denounced traditional heroic therapy. Arguing that heroic depletives including purges, cathartics and venesection caused more discomfort than they relieved, these physicians advocated watchful expectant management. This stance openly challenged the regular profession's authority. For centuries, the regular medical profession distinguished itself from other practitioners through use of heroic therapy; professional identity revolved around these practices. By abandoning heroic efforts, the profession felt they would be compromising their identity. Warner, Therapeutic Perspective, pp. 17-18.

successes of the regular profession's heroic armamentarium of therapeutics. These debates, focusing on the physician's capabilities to alter disease's natural course, argued that the traditional depletive heroic methods had equal efficacy as alternative practices; the regular practices offered no prognostic advantage. Nonetheless, the American Medical Association's bias permitted the sectarian practices to be tagged inferiorly.

At their core, these debates expressed frustration at the general impotence of any current therapeutic regimen. The physician's ability for accurate diagnosis and prognosis was never challenged. Medicine had established a fixed body of knowledge which both regular physicians and sectarians mastered⁶⁷⁵. Physicians first encountered the knowledge compendium as students. Up through the postbellum reconstruction, however, true diagnostic mastery was only achieved after years of clinical practice. Elsie Venner's Dr. Kittredge emphasized this point. "When a man that's once started right lives among sick folk as I've done for five-and-thirty years, if he hasn't got a library of five and thirty volumes bound up in his head at the end of that time, he'd better stop driving around and sell his horse and sulky"⁶⁷⁶. Moreover, transmission of medical knowledge progressed in a linear fashion from the elderly grand master to his young, hopeful student.

During the final two decades of the nineteenth century, the experienced physician descended from a place of respect to one of condescension. As scientific knowledge and research became an increasingly important component of medical practice, the focus of authority fell on the clinically inexperienced but

⁶⁷⁵The eclectic system curriculum, for example, accepted and taught conventional medical science. They only supplemented the therapeutics course with their own philosophies. Starr, op. cit., p.96.

⁶⁷⁶Holmes, Elsie Venner, p.210.

scientifically adept younger physician. The experienced physician's clinical judgement was no longer revered as a lifetime's wealth of accumulated knowledge but was often questioned and challenged for accuracy. By the dawn of the twentieth century, the younger physician had seized the leadership of the medical profession⁶⁷⁷.

This shift of authority from the older, clinically adept physician to the younger scientifically trained physician can be observed across the works included in this study. One potentially confounding variable, however, was the nineteenth-century literary representation of the physician as a Romantic hero. Inherent in this depiction was that he represented a "composite of all the qualities possible in a number of people at the peak of perfection"-including youth, vitality and an attractive wife⁶⁷⁸. In establishing this concept, Evelyn Wilbanks considered three 1880's novels including Dr. Sevier (included in this study), and another work by William Dean Howells. I will show, in my ensuing discussion, that this apparent bias does not confound my data and furthermore, is not carried out across my study.

In each of the three early novels both age and accumulation of practical experience were viewed as the quintessential marks of a good physician. Elsie Venner's Dr. Kittredge, "the leading physician of Rockland, was a shrewd *old* man, who looked pretty keenly into his patients through his spectacles,...,Sixty-three years old,-just the year of the grand climacteric. A bald crown, as every doctor should have. A consulting practitioner's mouth; that is movable around

⁶⁷⁷The great transformation in medicine correlated with the transfer of medical power and prestige from the generation born in the 1840's to that born between 1866 and 1876. This active transfer, taking place between 1895 and 1905, gradually shifted the reins of power from an established cohort of sixty year-old physicians to an upstart group of thirty-year-olds. King, Vignettes XVI, pp.1847-1850.

⁶⁷⁸Wilbanks, op. cit., pp.54-57.

the corners while the case is under examination, but both corners drawn well down and kept so when the final opinion is made up. In fact, the doctor was sent for to act as 'caounsel', all over the county and beyond it"⁶⁷⁹. The words 'old' and 'shrewd' are recurrent ones; Holmes featured them four times in a paragraph describing Dr. Kittredge's initial consult with the Venner family⁶⁸⁰. Other testimonials to his overwhelming experience founding his professional competence included: "The old doctor was a model for visiting practitioners"⁶⁸¹ and "So he [Kittredge] sat for a few minutes looking at her all the time with a kind of fatherly interest but with it all noting how she lay, how she breathed, her color, her expression, all that reaches the practiced eye so much without a single question being asked"⁶⁸².

Dr. Lagrange, "or as he much preferred to be addressed, Major Lagrange"⁶⁸³, also commanded community respect. The Mortons officially consulted Dr. Wendell to care for wounded Major Morton. Nonetheless Mrs. Morton asked Dr. Lagrange for an opinion on her husband, despite Dr. Wendell's presence in the room-an act noted for being outside the boundaries of approved consultation. Mrs. Morton was exceptionally pleased when the older doctor was permitted to speak his peace; "'I am glad that one doctor [Wendell], at least, can forget this eternal etiquette', exclaimed Mrs. Morton, a woman much used to having her own way"⁶⁸⁴. Dr. Wendell offered sufficient expertise while

⁶⁷⁹Holmes, Elsie Venner, p.98.

⁶⁸⁰Ibid., p.193.

⁶⁸¹Ibid., p.424.

⁶⁸²Ibid., p.425.

⁶⁸³Mitchell, In War Time, p.9.

⁶⁸⁴Ibid., p.47.

Morton was merely convalescing. Now that the wounded major developed a complication, Mrs. Morton relied on Dr. Lagrange, a trusted friend as well as experienced doctor. Had Dr. Wendell's level of experience instilled sufficient confidence in Mrs. Morton, she may not have been as impatient for Dr. Lagrange's consultation.

Dr. Jones, the physician who replaced Dr. Wendell also embodied the ideal of experience. "Dr. Jones, a more than middle-aged man, much known as reliable: a comfortable physician, too well satisfied with his art, 'and so sympathetic, my dear'"⁶⁸⁵. Dr. Jones's satisfaction with his art would imply more than passive indifference to the medical field's upcoming innovations. His style was warmly received by the 1860's Germantown community.

Dr. Wendell coupled an additional disadvantage to his youth: his fascination with scientific investigation. Wendell had a tendency to stay up late nights with "a few medical books, two or three metaphysical treatises, a mixture of others on the use of the microscope and on botany,...on the table was a small microscope, and a glass dish or two, with minute water plants, making a nursery for some of the lesser forms of animal and vegetable life. In a few minutes, Wendell, absorbed, was gazing into the microscope at the tiny dramas which the domestic life of a curious pseudopod presented. He soon began to draw it with much adroitness"⁶⁸⁶. Wendell, in 1863, was captivated by the microbiologic world and worked on this subject before it had gained much popularity in the United States. These pursuits compromised Wendell's clinical advancement.

⁶⁸⁵Ibid., p.236.

⁶⁸⁶Ibid., pp.15-16.

"It was nearly twelve o'clock when he was startled by hearing his sister call, 'Ezra, Ezra! Do go to bed. You will oversleep yourself in the morning'"⁶⁸⁷. As experience was considered the cornerstone of a good physician, Dr. Wendell's position at the hospital was particularly germane to advancing his career. The hospital exposed him to important clinical material that he might otherwise wait years to observe in clinical practice. Dr. Wendell, who "however well he did things-and he did many things well, he did none with sufficient intensity of purpose, or with such steadiness of effort as to win high success in any of them"⁶⁸⁸, would require total absorption in clinical medicine to garner desired experience. He could not afford to waste energy on superfluous scientific investigation.

Experience was the essential ingredient in the 1860's good doctor's command of authority. A younger doctor, as long as he could muster sufficient experience, could maintain a solid reputation. Dr. DuBois, in Tale of a Physician (1869) exemplified this hybrid: the clinically adept youth. Introduced as "yet under thirty, and unmarried"⁶⁸⁹, Dr. DuBois, "the studious and skillful doctor,..., had attained an enviable position in his profession. No other physician had ever been so successful with patients stricken with yellow fever. His name and fame were in every one's mouth"⁶⁹⁰. Dr. DuBois's experience was reinforced. When Carmo "involuntarily trembled from head to foot...this remarkable

⁶⁸⁷Ibid., p.16.

⁶⁸⁸Ibid., p.16.

⁶⁸⁹Davis, Tale of a Physician, p.55.

⁶⁹⁰Ibid., p.58.

manifestation of nervous excitement in the young man did not escape the observant, practiced eye of the physician"⁶⁹¹.

Dr. DuBois, however, was "an investigator and a progressive man...impelled by his constitutional inquisitiveness in truth's realms, he was reading and experimenting in the mysteries of magnetism"⁶⁹². Dr. DuBois was no happier than when he could discuss his theories on the hereditary nature of evil and often engaged Lawyer Ruggleston in hours of discussion. The lawyer, respectful of the physician's authority, "never hastily opposed what he often deemed his positive knowledge to the speculations to the speculations and theoretical assumptions of professional gentleman"⁶⁹³. Dr. DuBois, in spite of his youth, was "in point of fact...the most intelligent and the most successful medicine man in the Crescent City"⁶⁹⁴. Nonetheless, his experimental hypotheses were only marginally accepted.

While the 1860's supported that the best practicing clinicians were those with the most accumulated experience, Elsie Venner (1859) suggested a new, upcoming role for the young, aspiring physician. Just graduated, Bernard Langdon established himself in practice: "a genteel office, furnished it neatly, dressed with a certain elegance...and soon began to work his way into the right kind of business"⁶⁹⁵. Langdon's stint at practice lasted less than a year; he was soon engaged as a medical college professor⁶⁹⁶. The professor, responsible for

⁶⁹¹Ibid., p.235.

⁶⁹²Ibid., p.58.

⁶⁹³Ibid., pp.182-184 and see passage on pp.214-219.

⁶⁹⁴Ibid., p.58.

⁶⁹⁵Holmes, Elsie Venner, p.483.

⁶⁹⁶Ibid., p.485.

teaching contemporary medicine, was an optimal place for a young physician indicating a promising talent for diagnostics, embraced new ideas for medical sciences but lacked the practical experience to be of much value in demonstration.

Medical science proliferation only began to gather steam in the 1880's. Pivotal discoveries in germ theory⁶⁹⁷ were most noted for their newness than for their clinical value. The new technology's power more often frightened the 1880's practitioner⁶⁹⁸. The contemporary medical world was preoccupied with rapidly integrating medical advances into their familiar framework of established medical practice. The most prominent 1880's physicians considered medical science with much respect. Dr. D. Hayes Agnew, a prominent Pennsylvania surgeon⁶⁹⁹, assigned science a noble application in the quest for protecting and preserving human life. Preferring the more relaxed pace of "slow growth", he was especially critical of young medical upstarts who pushed for

⁶⁹⁷Prior to 1880, European advances in germ theory barely dented the American medical conscience. Robert Koch's 1882 discovery of the tubercle bacillus stimulated American interest in the germ theory and bacteriology. Still, by 1886, bacteriologic review articles only catalogued basic scientific discoveries. For the medical practitioner, there was little clinical value. King, Vignettes VIII, pp.794-798.

⁶⁹⁸Bacteriology, in particular, highlighted the difference between youth and experience. The 1880's medical literature was filling with papers describing the usefulness of microscopic examination of body secreta to formulate diagnoses. Most established physicians, having no practical microscopic experience, floundered with the new technology. Recent graduates, exposed to microscopy in medical school, could examine blood or sputum and actively incorporated these techniques. Elder physicians frequently engaged their younger colleagues as tutors and hired them to perform their clinical microscopic examinations. This role reversal served as one catalyst for upsetting the medical hierarchy. King, Vignettes XIX, pp.219-224.

⁶⁹⁹In 1889, Agnew represented the quintessential 1880's physician. He trained in the 1830's first as an apprentice in his father's rural practice then in medical school at the University of Pennsylvania. He embarked on a surgical career, obtaining various hospital appointments throughout Philadelphia, ultimately ending as chief professor at the University of Pennsylvania. Having established himself in a comparatively unscientific era, he was uncomfortable with the integration of scientific discoveries into the practice of medicine. Diana E. Long, "The Medical World of *The Agnew Clinic*: A World We Have Lost?", *Prospects*, vol. 11 (1986), pp.185-198.

rapid scientific discoveries⁷⁰⁰. Echoing Agnew's and his contemporaries' fears concerning experimental science's disruption of established medical practice, the 1880's novels placed a strong emphasis on practical experience as the standard for physician authority while they struggled to reconcile advancing experimental science.

Dr. Sloper, in Washington Square (1884), would fit Dr. Agnew's requirements. "His learning and skill were very evenly balanced; he was what you might call a scholarly doctor, and yet there was nothing abstract in his remedies...though he was felt to be extremely thorough, he was not uncomfortably theoretic...Doctor Sloper had become a local celebrity...he was some fifty years of age...he was an observer...and had none of the tricks and pretensions of second-rate reputations...he was fond of his practice, and of exercising a skill of which he was agreeably conscious...he desired experience, and in the course of twenty years he got a great deal"⁷⁰¹. Dr. Sloper had achieved the ranks of a local figure of authority. He practiced with clinical acumen. Despite espousing academic interests, Dr. Sloper never forgot his primary calling as a physician. He and never allowed his theoretical speculations to interfere with his practice.

The Undiscovered Country (1880) also supported that practical clinical experience was paramount to attaining a position of professional authority. Dr. Boynton received no respect for his attempts at research. Disapproving

⁷⁰⁰Agnew was particularly opposed to people who attempted to capitalize on the scientific explosion to catapult their own careers or to gain their own professional advancement. He seemed also petrified by the direction of the American culture in general that seemed to espouse "the self seeking grasping age" or the "mad haste for preferment of place or power". Agnew espoused the theory that an exclusively narrow focus on scientific study during the course of medical education would only produce an army of bad doctors. *Ibid.*, pp.185-198.

⁷⁰¹James, Washington Square, pp.5-7.

community members, labelling him an "unconscionable knave and quack"⁷⁰², threatened to actively interfere with his progress⁷⁰³. His lone supporter offered that "he's as good as gold, and as simple as a child,-but he hasn't got the practical virtues"⁷⁰⁴. He suggested the doctor leave Boston for a new opportunity to obtain professional authority⁷⁰⁵. Dr. Boynton's ensuing journey through the Shaker country delineated his path of clinical rediscovery. The journey culminated with Dr. Boynton, gravely ill, excited to consult with Dr. Wilson. "Dr. Wilson and I are treating my case together. By that means we draw the sting of the old proverb about having a fool for one's patient, and we get the benefit of our combined experience"⁷⁰⁶. Ultimately, in matters of human illness, Boynton accepted not only the irrelevance of his scientific attempts but the paramount reliance on clinical experience.

By the mid 1890's the medical profession had openly embraced the forthcoming scientific discoveries. With the formal closing of the Western frontier⁷⁰⁷, Victorian medical scientists accepted the ongoing challenge of continually pushing back the scientific frontier. Unlike the fear espoused fifteen years previous, these medical men welcomed new technologies. They heralded

⁷⁰²Howells, Undiscovered Country, p.54.

⁷⁰³ibid., p.58.

⁷⁰⁴ibid., p.77.

⁷⁰⁵ibid., p.79.

⁷⁰⁶ibid., p.278.

⁷⁰⁷The period between the last bonanza mining rush in 1877 and the Utah statehood in 1896 finally closed down the Western frontier. Three transcontinental railroads were completed in the 1880's and a fourth, the Great Northern, just before the 1890's depression. The Dakotas, Washington and Montana all achieved statehood in 1889, with Wyoming and Idaho joining in 1890. Wiebe, op. cit., p.11.

the new area, astounded that medicine had mired for so many years with "so many old ideas, half lights and shadows, tied to ratiocinations that had once fit comfortably within a single tome"⁷⁰⁸. While welcoming the new science, fin-du-siècle physicians remained extremely aware of their clinical responsibilities. These men strove to integrate the science of medicine with the art of healing, embracing a harmony between two very opposing ideals. The 1890's prided on this complementary relationship. "Medical science without art was inefficient while medical art without science was not only unprogressive, but almost inevitably quackery"⁷⁰⁹.

Spearman repeatedly emphasized Dr. Bryson's youth, especially in reference to his position as surgeon-in-chief. His initial description pinned Dr. Bryson as "only twenty-eight"⁷¹⁰. Nonetheless, "Bryson stood out. He was looked on as the coming man on this side; they really wanted him to take the chair"⁷¹¹. Youth was a focal attribute for Dr. Bryson's surgeon-in-chief appointment. Described as a "young deferential gentleman; smooth-faced and tall. He was quick and easy in movement; nervous energy flowed from his fingertips"⁷¹². Dr. Bryson was frequently asked by other, older, more experienced physicians for additional insight. "'By the way doctor', he [Dr. Kurd] added, speaking to the tall young man who by this time crossed to the lockers, 'I've got a case here I'd like you to look at in a minute-'"⁷¹³. June Borderly frankly added that "Kurd is one of

⁷⁰⁸Haller, Artful Science, p.232.

⁷⁰⁹Ibid., p.234.

⁷¹⁰Spearman, Doctor Bryson, p.80.

⁷¹¹Ibid., p.3.

⁷¹²Ibid., p.9.

⁷¹³Ibid., p.10.

the professors there, and Bryson is the professor"⁷¹⁴-"the smartest man in Chicago"⁷¹⁵. By dint of his youth, his advanced knowledge of academic and technical ophthalmology were the cornerstones of his superiority. "He's [Bryson] forgot more about eyes than Dr. Kurd will ever know"⁷¹⁶. Neither Mrs. Eliot nor June Borderly expressed any confidence in the older surgeon's operating skills⁷¹⁷.

Dr. Rast's authority also rested on his youthful embrace of scientific knowledge. Dr. Rast, "young, tall, handsome and overflowing with warmth for his fellows"⁷¹⁸, "felt himself more and more roused and breathless. Medicine after all was a part of his life-blood; the vast science that ventures and dares-grappling the Law and the World, in the service of man"⁷¹⁹. The foundations of his patient care were propelled by science. In the midst of a warrior's struggle against a young girl's pneumonia crisis point, Dr. Rast momentarily acknowledged that his battles were invariably linked to scientific progress. "He had done all that he-all that Science-could do: he was shattered, nerveless and broken. He could do no more...his strength and ammunition were spent"⁷²⁰.

Dr. Holden, too, incorporated scientific understanding into his clinical endeavors. Explaining the Spring's healing mystique, he suggested to "Try the healing water...it is mildly medicinal like all these warm springs-saline and

⁷¹⁴Ibid., p.19.

⁷¹⁵Ibid., p.25.

⁷¹⁶Ibid., p.18.

⁷¹⁷Ibid., pp.27-28.

⁷¹⁸Oppenheim, Doctor Rast, p.4.

⁷¹⁹Ibid., p.184.

⁷²⁰Ibid., p.105.

sulphurous-enough in it to make it disagreeable to the taste, and therefore make the sick to believe it has curative power"⁷²¹. Rather than tout the Spring as generic elixir, Dr. Holden transmitted sophistication through a more pharmacologic ingredient catalog. Dr. Holden, embracing the era's credo of combining science with the healing art, understood this hybrid valuation for Healing Springs-"It is the faith one brings to them rather than the chemistry of their water that is potent"⁷²².

Dr. Eliot Farrington, an eminent physician with prominent Washington clientele in The Healer, carried the confidence associated with youthful success. "As for Dr. Eliot Farrington, himself, he was a good example of the new doctor to be found in its full development only in the United States. There was not left in him the slightest trace of the barber-surgeon period of the profession-no obsequiousness, no sense of social inferiority to anybody. Nor was he of the familiar type of family doctor, although his field was general medicine...recognized as an all-around man of the world...during the comparatively few years since his return from Vienna...had built up rapidly a reputation as diagnostician and consultant...called his acquirements 'book science'...little of the (laboratory) scientist in him, less of the seer and nothing at all of the Puritan"⁷²³. Impossible only thirty years previous, Dr. Farrington succeeded to become a 'master diagnostician' with relatively little practical experience. Yet, this overwhelmingly sarcastic depiction dampened Dr. Farrington's apparent success. Believing that "manner and personality...had most to do with the success of a modern physician...Dr. Farrington's personality

⁷²¹Herrick, Healer, p.39.

⁷²²ibid., p.41.

⁷²³ibid., pp.261-263.

was a very winning one...always had the habit of good clothes and good society"⁷²⁴. Dr. Farrington forsook the art of healing and in its stead, through good manners and dress, created an illusion of medical care. By right, Dr. Farrington's dupe should have disqualified him from his authoritarian station.

Paramount to the turn-of-the-century society was the merging and harmonizing of contemporary science with the classical art of healing. Physicians lacking either component failed to command authority. Jane Grabo and the elderly physician who cared for Dr. Bryson's pneumonia were both examples of physicians lacking either of these talents. Jane Grabo was captivated by the technologic promises for cancer's cure. Exalting the scientist as "your only idealist-he alone throws out his vision into experiments"⁷²⁵, she decided to embark on a high-profile career of cutting-edge clinical investigation⁷²⁶. However, she only stood motionless as Dr. Rast chastised her clinical lapse-"You never paid attention!... Your sister has been sick for years! This is only the breakdown! And *you* want to be a doctor!"⁷²⁷. In contrast, Dr. Bryson mockingly described the elder Milwaukee physician as "an amiable old spider of a doctor here, a fine old fellow,...he showed me an old-fashioned lancet...that he took a cinder out of Long John Wentworth's eye when he was coming back from the Frémont convention in 1856...His views on the treatment coincide exactly with mine. That's reassuring"⁷²⁸. Dr. Bryson regarded this physician mostly as an

⁷²⁴Ibid., pp.262-263.

⁷²⁵Oppenheim, Doctor Rast, p.40.

⁷²⁶Ibid., p.47.

⁷²⁷Ibid., p.52.

⁷²⁸Spearman, Doctor Bryson, p.270.

historical curiosity and questioned his awareness and incorporation of contemporary therapeutic strategies.

The 1920's continued the trend of according increasing importance towards embracing science⁷²⁹. The novels, however, reinforced the physician's dual responsibility to both medical science and art. A good physician's authority continued to stem from excellent scientific understanding combined with the depth of human compassion. Otherwise one's scientific attainments were for naught.

David Noble, like Dr. Bryson, had been appointed surgeon-in-chief of a prominent institution at a particularly young age; "the youngest man, 'every one' said, that 'any one' could remember had been given such a position"⁷³⁰. Dr. Bryson's support was unanimous. Dr. Noble's was not. Despite being "strong as steel-can operate thirty six hours out of every twenty four, if necessary...he's got more skill in his little pinky...more than any doctor", his patients do not love him⁷³¹. The reason for his colleagues' dissent was that "He does slip up on his after-care...the *human* side doesn't touch him at all. He's pretty selfish...come right down to hard tacks"⁷³² and consequently, his colleagues unabashedly dissented against their highly trained and dexterous surgeon.

⁷²⁹During the decade following the World War I Armistice, scientific experimentation yielded a selection of medicine's watershed discoveries. In 1918, Einthoven developed the electrocardiogram through applying physical principles of electric currents and voltage drops to heart dynamics. Banting and Best uncovered the hormonal nature of insulin, its pancreatic source and its causative role in diabetes. The 1920's also witnessed the quest for antimicrobials which culminated with the 1929 discovery of Penicillin. Lyons and Petrucelli, *op. cit.*, pp.590, 592, 596.

⁷³⁰Keyes, *David Noble*, p.176.

⁷³¹*Ibid.*, pp.177-178.

⁷³²*Ibid.*, p.179.

Dr. Nye offered a more complete example of the preferred attitude. Upon his return to Ostable, with "hair, as thick as ever but sprinkled with gray upon the head and almost white at the temples; the deep lines between the brows and at the corner of the mouth", he was only thirty-six years old⁷³³. Despite this matured look, he was considerably younger than Dr. Parker, who "was usually the embodiment of professional dignity and fussy preciseness...He was an elderly man who made it his practice to camouflage his sixty-odd years"⁷³⁴. "Upon Dr. Nye fell the weightiest burden of those heavy weeks. Parker did his best but he was a much older man and not in the best of health"⁷³⁵. Advanced age was considered disadvantageous as the two physicians collaborated in the typhoid epidemic.

However, largest gully between Drs. Nye and Parker became evident while exploring the question of the pond's water quality. Dr. Nye, assuming the scientific perspective forcefully argued "Parker, has the water been analyzed? Are you, is the Company, sure that the water is pure, healthful, safe to drink...the bottom of that creek isn't clean sand, it is mud, and the cedar swamp is bedded with black muck and peat. All that thick growth on the hills drains into it in rainy weather and when the snow melts. There are cattle pastured on those hills, and barns and shanties beyond the swamp...in those days doctors hadn't been introduced to germs; they wouldn't have known one of they met it. If the water had killed a dozen people inside of ten years it wouldn't have been convicted...if your people have tested the pond, and know it's safe, I am satisfied"⁷³⁶. Dr. Nye

⁷³³Lincoln, Dr. Nye, p.52.

⁷³⁴Ibid., p.116.

⁷³⁵Ibid., p.288.

⁷³⁶Ibid., p.241.

not only found his case on experimental data but also related his concerns to modern science including bacteriology and engineering principles. Contrastingly, Dr. Parker's counter arguments reflected the touted empiricism of a past age. "Hallett's Pond has a reputation for its depth and the purity of the water...Do you imagine that men like Judge Copeland and Mr. Holworthy and Mr. Lee would deliberately plan to supply this town, and their own homes, with water that was impure?...Indeed! I should have thought the caliber of men at the head of the company would have been sufficient guarantee...I presume it has [been tested]"⁷³⁷.

Big cities with prominent medical institutions, like Boston, Chicago and New York, accepted the young disciple of science over the aged physician. This trend was equally prevalent in smaller towns such as Hamstead, Vermont and Ostable, Massachusetts. However, in small towns on the frontier's edge, like Wheatsylvania, North Dakota, the old traditions still prevailed. The older physician still commanded authority over the young upstart, irrespective of scientific reinforcements. This opinion trapped Martin Arrowsmith on his first night call. "Mary was a child of seven or eight. Martin found her lips and fingertips blue, but in her face, no flush. In the effort to expel her breath she writhed into terrifying knots, then coughed up saliva dotted with grayish specks...It was, he decided, laryngeal croup or diphtheria...No time now for bacteriological examination, for cultures and leisurely precision...He would use diphtheria antitoxin...it was too late for anything short of antitoxin or tracheotomy...In his mind all the while was the page in Osler regarding diphtheria, the very picture of the words: 'In severe cases the first dose should be

⁷³⁷ibid., pp.241-243.

from 8,000-' No. Oh, yes: '-from 10,000 to 15,000 units'...Swiftly, smoothly, he made intravenous injection of the antitoxin, and stood expectant. The child's breathing did not at first vary...There was a gurgle, a struggle in which her face blackened, and she was still...They knew the child was gone"⁷³⁸. The Novaks rewarded his efforts with "you killed her, with that needle thing! And not even tell us so we could call the priest!"⁷³⁹. Dr. Winters, the region's established physician suggested "Next time, in a crucial case, you better call some older doctor in consultation-not that you need his advice, but it makes a hit with the family, it divides the responsibility, and keeps 'em from going around criticizing"⁷⁴⁰. In the North Dakota plains, science had yet to win over the farmers' trust; the experienced physician still commanded authority and received the highest respect.

IV. The Eccentric Physician's Fate

In each of the four outlined periods, to command professional authority, a physician adhered to a particularly inflexible formula. In addition to specific educational curricula and preferred doctor/patient interactive styles, the good physician needed to exude confidence and bravery as well as exemplify the ideal, moral gentleman. With sufficient determination, each of these traits could be individually acquired. Proper mentorship provided both the didactic foundation and clinical patience and acumen required of the good physician. By accruing experience, even a faltering physician adopted a brave and self-confident attitude.

⁷³⁸Lewis, Arrowsmith, pp.160-162.

⁷³⁹Ibid., p.162.

⁷⁴⁰Ibid., p.163.

Altering one's system of moral values, usually entrenched since youth, was more challenging but not outside the realms of possibility. Dr. Sevier demonstrated this capability as he softened his views about the etiologies of poverty. Theoretically, any motivated physician could be numbered among the ranks of the good physician.

This equation, however, failed to account for a frighteningly essential element to any physician's success: the compatibility of his personality with that of his patient population. One intriguing concept stemming from this proposition was how regular was a regular physician required to be? Are the best physician personalities founded on conservatism and complacency? In a field touted for its innovative potential and endless creative drive to devise better methods to preserve human life could the eccentric personality have accessed the stratum of good physician? Four novels, each from a different time period, focused on an eccentric physician's career and wrangled with his admission into the fraternity of good physicians.

From the outset, Dr. Wendell was presented as an outlying personality, never quite at ease in the routine physician's costume. Dr. Wendell "was a man full of middle height: he stooped slightly, but the habit became oddly noticeable owing to his uniform...he wore a military cap, under which his hair curled softly. His features were distinct but delicate, and the upper lip, which was short, retreated a little, a peculiarity apt to give to the countenance a certain purity of expression...What an interesting face...and what a careless figure! And a soldier with a sun umbrella is rather droll."⁷⁴¹ Dr. Wendell's pursuits along his walk introduced his personality's uniqueness. "His face showed plainly that the mind was more alive than the body...he paused to pick up a flower, counted its

⁷⁴¹Mitchell, *In War Time*, pp.2-3.

stamina, and stowed it away in the lining of his cap. An insect on his sister's sleeve drew his attention. The trees, the passers-by, a monkey and a hand-organ at a street corner, all seemed to get in turn a share of alert, attentive regard"⁷⁴².

Dr. Wendell's eccentricity was most completely expressed through his preference for superficial dalliances in natural history, a preoccupation which he thought complemented but often superseded his medical interests. Captivated by "the elating influence of a new idea...he had been seized with the fancy that it would be interesting to search into, and elaborate on paper, the differences between American and European types of various maladies...Mere observation within restricted fields, under some organizing and applicative mind, should have been his sole function. When he came to a point in his studies where it was needful to compare acquired facts, in order to know how to observe further...he began to find difficulties which usually ended in barring his path, until some newer, and because newer more fascinating, subject attracted for a time his easily exhaustible energy"⁷⁴³.

Dr. Wendell, however, was not only oblivious to his tremendously distinctive personality but also this eccentric personality's impedance on his career. On several occasions he wondered about his repeated inability to achieve success. "In measuring himself with others, he saw that in acquisitions and mind he was their superior, and he was constantly puzzled to know why he failed where they succeeded"⁷⁴⁴. Furthermore, "his capacity to be pleased with the

⁷⁴²ibid., pp.2-3.

⁷⁴³ibid., p.112.

⁷⁴⁴ibid., p.5.

recurrent dreams of possible future intellectual achievements was as remarkable as his failure to see why he constantly failed to realize them"⁷⁴⁵.

As a physician, Dr. Wendell's biggest failure was not his inability to publish meaningful research documents or maintain a prolonged attention span. Most importantly, he failed to communicate to his patients a sense of familiarity, a spark of recognizable mannerisms that would encourage the doctor-patient bond to gain their trust and respect. His career was fraught with failure. He previously attempted the "trials of a practicing physician in the town where he was born. The experiment failed. There was some want in the young man which interfered with successes at home, so that the outbreak of the war found him ready...to welcome the chances of active service as a doctor in the field"⁷⁴⁶. This second military career also aborted. A rough campaign in West Virginia resulted very soon in his suddenly quitting the army..."⁷⁴⁷. One can only divine whether the rough campaign was personal or military. Colonel Fox, a very masculine Civil War soldier, identified Dr. Wendell "with his microscope and his queer vermin and his musty old books"⁷⁴⁸ as inferior. On several occasions, Dr. Wendell was the brunt of the ladies' gossip. They catalogued multiple shortcomings. "He was always a rolling stone...and he was a rolling stone in his opinions, too. Never could hold fast to anything"⁷⁴⁹. "There was always something queer about him"⁷⁵⁰. "I don't think that people here appreciate Dr.

⁷⁴⁵Ibid., p.113.

⁷⁴⁶Ibid., p.11.

⁷⁴⁷Ibid., p.11.

⁷⁴⁸Ibid., p.104.

⁷⁴⁹Ibid., p.236.

⁷⁵⁰Ibid., p.236.

Wendell's abilities. He ought to be in a great city"⁷⁵¹. The ladies acknowledged the incongruency between Dr. Wendell's and their personalities and agreed that he would never locally obtain the authority they bestowed on respected physicians. Having been cast as an eccentric, Dr. Wendell's fate was doomed among the uppercrust Germantown set.

Dr. Boynton, in The Undiscovered Country, offered an 1880's perspective on the eccentric. Dr. Boynton's eccentricity is depicted through his unflinching beliefs in Spiritualism and the Medium. Using his daughter as the medium, he vowed, "if our experiments progress as favorably as they have for the last six months,...to render the invisible agencies of these sounds as sensible to sight as to hearing"⁷⁵². He was simply "at the disadvantage that every man must be whose habits of life and temperament remove him from personal encounter"⁷⁵³. Dr. Boynton struggled to synchronize his personality quirks with society. Like Dr. Wendell, he could not retain sufficient authority to establish a promising practice. Should he return to his hometown, they would "starve there. My practice had dwindled to nothing before we left...Their miserable bigotry could not tolerate my opinions"⁷⁵⁴. He was equally unsuccessful in Boston. Ford labeled the Doctor as "the most unconscionable knave and quack I have ever seen"⁷⁵⁵. Hatch offered a misdirected compliment; "he's as good as gold, and as simple as a child, but he hasn't got the practical virtues-or vices, whichever you

⁷⁵¹Ibid., p.185.

⁷⁵²Howells, Undiscovered Country, p.10.

⁷⁵³Ibid., p.55.

⁷⁵⁴Ibid., p.62.

⁷⁵⁵Ibid., p.54.

choose to call 'em"⁷⁵⁶. Even the Shaker sisters recognized his atypical bedside manner while tending the febrile Egeria. "If he's got anything on his mind, it ain't his daughter...I told him I thought she was going to have a fit of sickness, but he said it wa'n't anything but exhaustion, and 't he'd see after her; 't he was a doctor himself. To my knowledge he hain't been near her since"⁷⁵⁷. As for Dr. Boynton, he was both confused by his failures and oblivious as to why he was perpetually embroiled in conflict. "I am an honest man! I have an unsullied life behind me, spent in the practice of an honorable profession and in earnest research into questions, into mysteries, on the solution of which the dearest hopes of the race repose. Who are you, to attaint me of unworthy motives, to cry pretender and imposter at me?"⁷⁵⁸.

Arrowsmith's Dr. Max Gottlieb was "the mystery of the university"⁷⁵⁹. Unlike the other great professors, "he dwelt in a cramped cottage whose paint was peeling, and rode to the laboratory on an ancient and squeaky bicycle"⁷⁶⁰. "It was known that he was born a Jew, born and educated in Germany, and his work on immunology had given him fame in the East and in Europe. He rarely left his small brown weedy house except to return to his laboratory, and few students outside of his classes had ever identified him...A thousand fables fluttered about him...it was said he could create life in the laboratory, that he could talk to the monkeys which he inoculated, that he had been driven out of Germany as a

⁷⁵⁶Ibid., p.77.

⁷⁵⁷Ibid., pp.168-169.

⁷⁵⁸Ibid., p.54.

⁷⁵⁹Lewis, Arrowsmith, p.9.

⁷⁶⁰Ibid., p.126.

devil-worshipper or an anarchist, and that he secretly drank real champagne every evening at dinner...he did not hurry like the belated home-bodies. He was unconscious of the world...He was lost in the shadows, himself a shadow"⁷⁶¹.

In his laboratory, Dr. Gottlieb was equally beguiling. He "had turned back to his desk which was heaped with shabby note-books, sheets of calculations, and a marvellously precise chart with red and green curves descending to vanish at zero. The calculations were delicate, minute, exquisitely clear; and delicate were the scientist's thin hands among the papers. He looked up, spoke with a hint of German accent. His words were not so mispronounced as colored with a warm unfamiliar tint"⁷⁶². His eccentric's life was tainted with melodrama. His experiments plunged him towards his "long, lonely, failure-burdened effort to synthesize antitoxin, and his diabolic pleasure in disproving his own contentions as he would those of Ehrlich"⁷⁶³. Dr. Gottlieb considered his Winnemac career a disappointingly lonely dead end; "at Mohalis, there was no one who was interested, no one to stir him...'no I have done nothing except be unpleasant to people that claim too much, but I have dreams of real discoveries some day"⁷⁶⁴. Martin Arrowsmith's admiration grew from his being more than a genius; Dr. Gottlieb was "a man who had headaches, who became agonizingly tired, who could be loved"⁷⁶⁵.

⁷⁶¹Ibid., pp.9-10.

⁷⁶²Ibid., pp.11-12.

⁷⁶³Ibid., p.10.

⁷⁶⁴Ibid., p.38.

⁷⁶⁵Ibid., p.13.

Dr. Gottlieb possessed a unique keenness and explored scientific principles unlike any of his contemporaries. "He was of the great benefactors of humanity. There will never, in any age, be an effort to end the great epidemics or the petty infections which will not have been influenced by Max Gottlieb's researches, for he was not one who tagged and prettily classified bacteria and protozoa. He sought their chemistry, the laws of their existence and destruction, basic laws for the most part unknown after a generation of busy biologists"⁷⁶⁶. Nonetheless, he was dreadfully unsuccessful at winning his colleagues' admiration, respect and understanding. Chastised by anti-semitism, he fled Germany. At his first American position, the Hoagland Laboratory in Brooklyn, his colleagues relegated him as a "cranky Jew catching microbes by their little tails and leering at them-no work for a tall man at a time when heroes were building bridges..."⁷⁶⁷. At Winnemac, he was no more successful. Humanities professors Brumfit and Edwards mocked Dr. Gottlieb's scientific credo⁷⁶⁸. Dr. Gottlieb, entranced by his dream of creating a scientifically rooted medical school, enraged Dean Silva, a "courteous old gentleman...a fit disciple of Osler"⁷⁶⁹ by suggesting the latter's resignation. Dr. Gottlieb was ultimately dismissed from the school under pretext of "disloyalty to his dean, his president...disloyalty to recognized medical and scholastic ethics. Insane egotism. Atheism. Persistent failure to collaborate with his colleagues..."⁷⁷⁰. Like Drs. Wendell and Boynton

⁷⁶⁶Ibid., p.125.

⁷⁶⁷Ibid., p.124.

⁷⁶⁸Ibid., pp.12-13.

⁷⁶⁹Ibid., p.129.

⁷⁷⁰Ibid., p.130.

before him, Dr. Gottlieb's well-meaning but misconstrued eccentric perspective on society steered him towards a bumbling, struggling life.

For a brief moment at the McGurk institute, Max Gottlieb achieved scientific success and personal happiness. He was granted chair of the Department of Immunology with ample time and patience to pursue his careful work. He became fast friends with the Institute founder, the industrialist shipping magnate, Ross McGurk⁷⁷¹. His quiet, reclusive ploddings gained him sufficient admiration to be elected Director of the Institute when he had not even campaigned⁷⁷². The success overburdened his fragile foray into society. "While he was supposed to radiate benevolence from the office...Gottlieb clung to his own laboratory...as a cat clings to its cushion under a table. Once or twice he tried to sit and look impressive in the office of the Director, but he fled from the large, clean vacuity...The Directorship devoured enough time and peace to prevent Gottlieb from going on with the ever more recondite problems of his inquiry...and his inquiry prevented him from giving enough attention to the Institute to keep it from falling to pieces"⁷⁷³.

Even in his death, Dr. Gottlieb was left alone, lost in his own eccentric reality. He had developed a senile dementia. "He doesn't know anyone...His memory is gone. And he's just suddenly forgotten all his English. He can only speak German...The old man looked as though he half understood...His arrogant eyes were clouded with ungovernable slow tears"⁷⁷⁴. "Max Gottlieb sat

⁷⁷¹ibid., p.294.

⁷⁷²ibid., p.332.

⁷⁷³ibid., p.337.

⁷⁷⁴ibid., p.403.

unmoving and alone, in a dark small room above the banging city street. Only his eyes were alive"⁷⁷⁵.

Drs. Wendell, Boynton and Gottlieb, three eccentrics residing on the fringes of medical society, were each involved in innovative scientific investigation. Yet, it would be erroneous to mark scientific curiosity as a hindrance to good doctoring. Dr. Andrew Hecht (Dr. Rast's colleague who experimented with immune prophylaxis against typhoid), Dr. Graham -- (Dr. Holden's acquaintance who "for more than five years-ever since he had graduated from the medical school-this quiet little man had been absorbed in one pursuit-the discovery of an anti-toxin for pneumonia...It was the cleanest passion of idealism known to our day that animated him,-devotion of the medical scientist in pursuit of diseases and their antidotes"⁷⁷⁶) and Dr. Terry Wickett (Dr. Arrowsmith's cynical and idealistic collaborator who left McGurk to "patent the process of his quinine derivative and retired to Birdie's Rest, to build a laboratory out of his small savings and spend a life of independent research"⁷⁷⁷ all displayed scientific genius. None behaved eccentrically; each embodied a highly respected physician.

The eccentric physician also needed not to be a scientist. Dr. Eric Holden, the turn-of-the century trailblazing physician, proffered a different point of view on the eccentric physician. Like Drs. Wendell, Boynton and Gottlieb, Dr. Holden selected an atypical career path. Rebelling against increasing medical commercialism and fighting narcotics abuse, he left the big city glitz and prestige

⁷⁷⁵Ibid., p.448.

⁷⁷⁶Herrick, Healer, p.251.

⁷⁷⁷Lewis, Arrowsmith, pp.422-423.

for the wilderness's purity and opportunity for rebirth⁷⁷⁸. This choice castigated him-"then what's he doing way off here in the wilderness? There must be something wrong about him or he wouldn't have hidden himself away in this hole!"⁷⁷⁹. Dr. Holden's first contact with the vacationers emphasized his unusual demeanor. He possessed a "large, thin face, curiously pallid beneath the sparse black beard, over the gaunt figure clothed in a rough faded mackinaw and stained brown trousers...worn moccasins and coarse woolen socks...this uncouth backwoodsman"⁷⁸⁰. Following this introduction, he was referred to only as 'the stranger'⁷⁸¹ and then 'the Wild One'⁷⁸², reinforcing his eccentric disposition.

As long as Dr. Holden persisted in his wilderness idealism, he could not muster sufficient professional authority. Nell's wealthy uncle, the Colonel, faltered at recognizing Dr. Holden's worth. "How do you [Holden] propose to support a wife? Practicing medicine up there in the woods? A fine prospect that for a refined girl, treating dirty half-breeds"⁷⁸³. Nonetheless, Dr. Holden, upon establishing his Healing Hospital, remained steadfast in treating the native population; "'these are my people! They have no other helper...Elport [a rich industrialist] can send for whom he likes'...her husband seemed imperturbably convinced of his own methods"⁷⁸⁴.

⁷⁷⁸Herrick, Healer, pp. 50-51.

⁷⁷⁹ibid., p.6.

⁷⁸⁰ibid., pp.7-8.

⁷⁸¹ibid., pp.9-16.

⁷⁸²ibid., see points all over novel. e.g.-p.90, p.92.

⁷⁸³ibid., p.93.

⁷⁸⁴ibid., pp.132, 134.

Following Dr. Holden's and Nell's marriage, his career successes increased only in parallel with Nell's stabs at erasing hints of her husband's eccentricity. Her first strike induced Dr. Holden to accept Elport as a patient. The railroad industrialist not only thrived on building Dr. Holden's hospital, but he succeeded in accelerating its completion by hiring tradesmen and infusing capital to complete the job and equip the facility⁷⁸⁵. Dr. Holden, however, still retained his idealism and scoffed Elport's vision of running "what he calls a 'hydropathic establishment'-gull the public with spring water! Wheedle the rich out of their money and coddle a lot of old men and women who ought to die anyway-or get out and work for their living!...I didn't come up here to the woods for that. Let 'em play quack in the cities"⁷⁸⁶.

Her second manoeuvre moved the family out of the isolated stone cabin and into Eyrie, the great manor house owned by her uncle. "The house expenses in the Eyrie were necessarily large"⁷⁸⁷. Within weeks, "some new patients came to the Spring, of the sort who could amply pay for their entertainment, and this time they were not refused"⁷⁸⁸. Construction added new buildings to the Hospital. With these changes, "surely he [Holden] was more 'like other people' nowadays...gradually, the doctor was called less and less to the distant camps...he was becoming more and more the modern man of medicine,-the successful practicing physician, half-trickster, half-healer-running an hotel for the rich sick,

⁷⁸⁵ibid., pp.139-146.

⁷⁸⁶ibid., p.144.

⁷⁸⁷ibid., p.225.

⁷⁸⁸ibid., p.226.

selling his gift for the thirty pieces of silver...the current was drifting him fast into the inevitable"⁷⁸⁹.

Visiting the city dealt the final blow. Attending a dinner party, Vera Travers characterized Dr. Holden, in "his ancient clothes and his cravat rumpled untidily about his high collar (his wife had tried her best to get him properly prepared for this dinner...but he refused to order new clothes, and had returned from a day spent at the hospital so late that he had merely time to throw on the suit she had unpacked for him)"⁷⁹⁰, as "imperfectly tamed"⁷⁹¹. While he argued against Dr. Farrington's pompous, unconditional acceptance of German philosophies, his wife wished that he were "only a little more like other people"⁷⁹². He returned to the wilderness with gross alterations to his Healing technique. "Formerly, he had made his first round of visits before breakfast, but these days he rarely got started by ten o'clock...I gave her [a patient] a hypodermic this morning', Dr. Percy said. Holden nodded. There was a time when the use of the little needle at the Healing Spring would have caused a revolution, especially if used by anyone but Holden "⁷⁹³. Previously, Dr. Holden tramped for miles to treat an ailing half-breed; of late "he don't seem to know half the time if a patient is here. He prescribes and leaves the details to the young doctors-they carry out the cure, you know"⁷⁹⁴. He would dismiss a forlorn, desperate pilgrim. "'We do

⁷⁸⁹Ibid., pp.229-231.

⁷⁹⁰Ibid., p.263.

⁷⁹¹Ibid., p.260.

⁷⁹²Ibid., p.271.

⁷⁹³Ibid., pp.301-302.

⁷⁹⁴Ibid., p.319.

not take patients who come unrecommended...you should have sent me word at least'...The doctor frowned and moved as if he would continue in his path and leave her there...The woman quivered as if he had dealt her a death blow"⁷⁹⁵.

Dr. Holden recognized his transformation. "I thought I had the gift [of Healing]...-something more than mere knowledge or skill,-something more than myself!...'Tis based on will-pure will...Will born in pain and effort, forged in the fire...the will to live, the will to do!...I gave them [the sick] what I had struggled for and won myself...Years ago when this was all a great wilderness I came here alone, sick in body and mind...One day chance took me out of it-I saw a light...But the evil has come back...I thought I had conquered the evil-possessed my will wholly. I began to work, to make cures...It was a great delusion...I was merely in love with a woman...I lived on the wings of the wind-I was to be more than man...But I came soon to earth...I have stayed on the earth ever since-it is hard and solid, the earth...I remain on the earth and prosper. Sell my drugs and talk-delusions to the good people who are eager to pay me a round sum for them"⁷⁹⁶.

Dr. Holden's situation percolated with irony. It was when the vacationing community labelled Dr. Holden as eccentric to an extreme that he possessed his magical healing powers and soared among the clouds. Only when he adopted respectable, predictable mannerisms did he crash to the Earth and alter his practice. As a respectable physician, Dr. Holden no longer Healed all distraught souls deposited on his doorstep. He had, by degrees, exchanged his eccentricity for respectability. He simultaneously sold out his idealism, compassion, responsibility and *raison-d'être*, all qualities valued in a good physician. Dr. Holden, like the other eccentric physicians, could not command authority from

⁷⁹⁵ibid., p.311.

⁷⁹⁶ibid., pp.332-334.

neither his upper-class patients nor his colleagues. Yet, the eccentric Dr. Holden better qualified for the role of good physician.

DISCUSSION: RECOGNIZING THE GOOD PHYSICIAN

The toughest challenge facing today's medical profession is accepting the necessity of change. The initiative for change, fuelled by the Clinton proposals, is gathering sufficient momentum to significantly alter the medical profession's status quo. The American Medical Association has primarily classified this impetus within an economic perspective and has focused on the physician's ongoing struggle to acclimate to the rigors of managed care⁷⁹⁷. However, there is an equally important but less touted personal facet to this impending change. Physicians have only begun to recognize the necessity to adapt their individual practice styles to the new millennium's forecasted needs⁷⁹⁸. Seizing this opportunity could launch the physician towards his most important, prominent role in recent history⁷⁹⁹. By reestablishing the professional good doctor image, physicians will be most aptly poised to claim their rightful responsibility of leading American health care.

The good doctor's image is complex. The same essential components remain integral towards defining the good doctor. However, influenced by both

⁷⁹⁷Julie Johnsson, "The Doctor's Toughest Challenge: Accepting the Necessity of Change", *American Medical News* (January 17, 1994), pp.3-5.

⁷⁹⁸A recent periodical article catalogued skills projected to play an essential role in practicing 2005's medicine. A substantial portion would require the physician to adjust his practice. Importantly, the physician should appreciate his demanding, knowledgeable patients and strive to practice in partnership with them. In this context, the physician should differentiate the opportune moments to involve patients in the decision process from situations best solved by the physician alone. The physician must remember diseases' psychosocial perspectives as emphatically as the pathophysiological. In addition, preventative care as well as ethical considerations would figure prominently, supplanting the current acute interventional focus. Flora Johnson Skelly, "Managing Prevention, Cost, Ethical Issues Will Be Key Clinical Skills of the Future", *American Medical News* (January 17, 1994), pp.3-5.

⁷⁹⁹ Dr. Donald L. Fink, Vice Chairman of the Department of Family and Community Medicine at the University of California, San Fransisco, quoted in Skelly, op. cit., p.4.

contemporary medical advances and socio-political climates, the good doctor composite is unique to a given historical period. This examination of twelve American novels spanning 1859 to 1925 characterized the contemporary good doctor, while emphasizing his evolution across four defined historic periods. Within the context of history, I have discriminated the good doctor through his educational achievements, his involvement in the doctor/patient relationship and his success at achieving professional authority.

Educationally, the 1860's good doctor distinguished himself by simply completing a regular medical curriculum. Physical diagnosis and disease natural history formed this curriculum's cornerstones. Although the good physician could supplement his regular background with sectarian philosophies, an exclusively sectarian perspective negated his regular professional affiliation. Only the regularly trained 1860's physician could achieve the good doctor status. By the 1900's, the regular physician had further constraints placed on his good doctor's education. The good doctor required attendance at a university-affiliated medical college that offered substantial exposure to both experimental laboratory science and clinical bedside teaching. Proprietary programs had acquired substandard reputations and were considered unable to produce a good doctor.

By the 1920's, the establishment of medical specialties created two educational standards: that preparatory for the good specialist and that germane to the good generalist. The new extremes of premedical and postgraduate medical education were considered not only desirable but essential for the good specialist. This in-depth training both disciplined the specialist to focus on a narrow slice of medicine and sparked his experimental curiosity, stimulating research. Yet, these standards were considered excessive for the generalist. Through his portrayal of the archetypal post-Flexnerian curriculum, Sinclair Lewis argued that these medical schools preferentially exalted cold, exacting

students over their even-tempered, humanistic counterparts. This trend compromised the production of the good generalist doctor.

Throughout the studied period, the good doctor remained ambivalent to European influence. The Parisian school produced good physicians like Dr. DuBois. Yet, Henry James argued that practicing Parisian philosophy fostered a distanced insensitivity towards the patient which directly countered his good doctoring ideal. The rise of German programs also generated conflicts. While Americans strove to mimic German expertise, the German scientist, distinguished by his ethnicity, was scoffed and ridiculed. Competing with the German standard, 1900's American medicine ultimately succeeded in surpassing European advances. By 1915, any European requirement of the good doctor fell into obsolescence.

The evolution of the doctor/patient relationship exemplified the influence of an historical setting on good doctoring. Highly attuned observational skills remained the only consistently valued good doctor requirement. Reassurance, intervention, advice and explanation all fluctuated in importance across the seventy-five year span.

Reassurance followed a convoluted, tortuous course across the considered time interval. The society of the 1860's valued reassurance as the principal marker for the good physician. Although remaining a continually essential component, during the following forty years reassurance was supplanted as the good physician's top priority. The 1880s witnessed the physician's renewed therapeutic activity and a valuation of intervention above reassurance. In the absence of planned intervention, reassurance resounded an empty quality. By the 1900's, reassurance jockeyed with intervention for second priority behind explanation in the good physician's repertoire. Nonetheless, lack of a reassurative technique disqualified the physician of the 1900s from good

doctoring. By 1920, reassurance was once again firmly entrenched as paramount to establishing successful patient rapport. Patients, leery of the eager surgeon and distanced by the technically overinvolved specialist, gauged a physician's trustworthiness and goodness from his demonstration of reassuring techniques.

The relative therapeutic impotence of the 1860s relegated intervention to an almost negligible status. Subsequent to the development of physiologically directed therapeutics as well as exponential progress in surgical technique, intervention acquired considerable attention in the 1880's and 1900's. Interventional willingness coupled with crisp decisive action distinguished the good physician. As interventions defined the good physician, 1900's specialists hoped to gain additional prominence by hoarding their procedures. Disempowered, contemporary generalists struggled to redefine their usefulness. Entering the 1920's, intervention slipped in prominence. The American public, frustrated with overbearing, authoritative specialists, avoided interventions unless sweetened with kind tenderness. The good doctor ultimately combined crisp interventions with reassuring compassion.

Explanation, paralleling experimental scientific discoveries, gained prominence in the early 1900's. The proliferation of scientific knowledge finally presented the physician the opportunity to discuss disease etiology beyond the obvious constellation of signs and symptoms. Patients appreciated explanations and actively sought physicians willing to satisfy their curiosity. The good physician was regarded as one who, no matter a situation's urgency, freely produced a substantive explanation. Equally important, the good physician needed to recognize his constituent population's capacity for understanding and tailor his explanations to their capacity. At the extreme, the good doctor acknowledged those situations where the best explanation was none at all.

Explanation retained its importance through the 1920's. A new motivation, however, guaranteed this position. The skeptical 1920's patient demanded explanations to allay concerns of receiving unnecessary or unfounded procedures.

Although its relative importance fluctuated, advice nonetheless persisted only as a good doctor's secondary trait. Advice was most sought in the 1860's, where it often masqueraded as the good physician's intervention. Good physicians continued to dispense advice through the 1880's and 1900's. By 1920, advice had all but disappeared from the good physician's repertoire.

Between 1859 to 1925, the medical profession struggled with an attempt to establish professional authority. Within this period, the good physician relied his authority on three basic principles. The first, the principle of specificity, respected each medical case's individual and unique nature. It figured most prominently in the study's first decades and subsequently declined with the development of disease-targeted therapeutics. However, both 1880's and 1920's good physicians invoked this principle following the failure of more contemporary diagnostics.

Twentieth-century physicians were most apt to ground their authority in scientific advancement. Although science offered justification for the 1880's good physician's research, by the turn of the century, the good physician adopted a scientific basis for clinical medicine. The good physician's acceptance of science resulted in the concomitant rejection of medical empiricism as a potential authority source. By the 1920's, scientific authority acquired a macabre position. Ordinary physicians, hoping to elevate themselves to a higher echelon of goodness, attempted to invoke science as their authority. However, they fostered scientific sensationalism and peppered their positions with fantastic but fabricated statistics. These physicians, misunderstanding science's true calling, failed to qualify as good doctors.

Nature, the third source of authority, remained constant within the good physician's repertoire. In each period physicians invoked its power. Linked to nature's authority was the shifting supercedence between the 'natural' state and the 'normal' state. Recognizing nature's power, the good physician readily recognized that a patient's natural state may present outside the accepted limits of normal values.

Integral to the good physician was his ability to project his professional authority. Across the entire time period, several characteristics continuously distinguished the good physician. He carried the title 'doctor', presided over life and death, accounted for all his professional interventions and demonstrated bravery and self confidence. The good physician also displayed moral rectitude. In his personal affairs he was right and just. Professionally, he upheld the American Medical Association's code of ethics and its successive revisions.

Yet, there were some traits that inhibited a physician from commanding authority, thus limiting his goodness. No matter his intentions, the eccentric physician's personality hampered his efforts at commanding authority. To a small extent, a physician's outward appearance and comportment in society reflected his goodness. Practice size was a simple barometer to measure the good physician. The good physician also needed to distance himself from excessive drinking and other less virtuous extracurricular pursuits. The ensuing gossip invariably tarnished his reputation. Other external accoutrements, however, did not distinguish the good physician. Although the carriage/automobile facilitated the physician's lifestyle, their rumblings did not specifically announce a good physician. Contrary to D. W. Cathell's suggestions, neither fashionable dress nor conservative, contemporary office furnishings were markers of the good physician. Furthermore, the good physician was not hampered by a patient population built among 'the great unwashed'. As testament to his goodness, the

good doctor could muster a successful practice even in the most hostile environments.

The interplay between the old, experienced physician and his younger but scientifically adept counterpart outlined the final criterion for professional authority. Through the 1860's and 1880's, the elderly physician, bolstered by a lifetime of practical experience, embodied the prototypical good physician. By the turn of the century, however, scientific advances both outdated traditional philosophies and promoted fresh laboratory and interventional techniques. The young physician, versed in these new applications, was the preferred consultant. Despite his relative lack of experience, his authority stuck. Contrastingly, his elderly counterpart, stripped of his authority, had become a medical dinosaur. From the early 1900's, the quintessential good physician harbored a youthful embrace of science.

The changes set to affect medical practice in the 1990's have already begun. Specifically, these are reflected in the primary care physician's recent resurgence. For the past two decades, primary care medicine has been touted as "second class training"⁸⁰⁰. Family physicians have been continually frustrated by the dissemination of "inappropriate and negative information...commonly disseminated by other specialists"⁸⁰¹. Despite the concurrent increase in available residency positions, American medical students failed to show interest in these programs⁸⁰². As recently as 1992, primary care specialists have published articles

⁸⁰⁰Mark Lipkin, Jr., W. Levinson, R. Barker, D. Kern, W. Burke, J. Noble, S. Wartman, & T.L. Delblanco, "Primary Care Internal Medicine: A Challenging Career Choice for the 1990's", *Annals of Internal Medicine*, vol. 112 (1990), pp.371-377.

⁸⁰¹J.E. Scherger, J.W. Beasley, G.I. Gaebe, D.E. Swee, N.B. Kahn, & Wm.M. Rodney, "Responses to Questions About Family Practice as a Career", *American Family Physician*, vol. 46 (1992), pp.115-125.

⁸⁰²Lipkin, et. al., op. cit., pp.371-377.

attempting to correct their tarnished images. Frequently, these articles included recruitment pleas to medical students. This status quo is on the verge of dramatic reorganization.

To an audience at Johns Hopkins Medical School, Hillary Rodham Clinton indicated her inclinations to restructure the reformed health care system around the primary care provider. Advocating an emphasis on preventative medicine, she challenged medical schools to revamp their curricula to increase primary care exposure⁸⁰³. Hospitals will be required to restructure residency programs to graduate fifty percent primary care candidates⁸⁰⁴.

Traditionally, the romanticized family doctor represented the idealized good physician⁸⁰⁵. Recently, subspecialism trends have slowly eroded the generalist's professional identity⁸⁰⁶. Contemporary renewed interest in the generalist provides primary care physicians with the unique opportunity to reestablish their authority as the quintessential 'good doctor'. Following careful consideration of those traits contributing to the good doctor's image of a bygone era, today's physician, both generalist and specialist, might better appreciate specific elements integral to his/her own attainment of the good doctor's status. In War Time's Miss Clemson best characterized this forthcoming challenge. Reflecting on her conception of the good doctor she commented: "I think myself

⁸⁰³Barbara J. Culliton, "Hillary Clinton Lobbies at Hopkins for Health", *Nature*, vol. 363 (1993), p.571.

⁸⁰⁴Patterson, One Dean's Perspective, pp.2-5.

⁸⁰⁵In her thesis, Mary Ann Cook described the quintessential physician as "a dedicated family physician making housecalls in the middle of the night, often travelling long distances into the country; a doctor who is intimately acquainted with both the medical and social histories of his patients". Cook, Patient Satisfaction, p.2.

⁸⁰⁶Council on Long Range Planning and Development in Cooperation with the American College of Physicians, the American Society of Internal Medicine, and the Society of General Internal Medicine, "The Future of General Internal Medicine", *JAMA*, vol. 262 (1989), pp.2119-2124.

that it is very difficult to judge of a physician. We haven't the opportunities or even the knowledge"⁸⁰⁷.

⁸⁰⁷ Mitchell, In War Time, p.185.

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